

Name De Sai Ram. Date of Birth \_\_\_\_\_PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

|                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Heart/Lungs</b><br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Heart Disease ( <i>valve, vessel, rheumatic, etc.</i> )<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Pneumonia | <b>Stomach/Bowel</b><br><input type="checkbox"/> Celiac Disease<br><input type="checkbox"/> Irritable Bowel Syndrome<br><input type="checkbox"/> Stomach/Duodenal Ulcers<br><input type="checkbox"/> Ulcerative Colitis/Crohn's<br><input type="checkbox"/> Other Liver, Stomach, or Bowel Disease                                                                                                                      | <b>Hematology/Oncology</b><br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Bleeding Disorders<br><input type="checkbox"/> Blood Clots/Clotting Disorders<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Radiation Therapy | <b>Anesthesia History</b><br><input type="checkbox"/> Difficult intubation<br><input type="checkbox"/> Malignant hyperthermia<br><input type="checkbox"/> Post Op Nausea or Vomiting (PONV)<br><input type="checkbox"/> Pseudocholinesterase Deficiency<br><input type="checkbox"/> Spinal headache                                            | <b>STDs</b><br><input type="checkbox"/> Chlamydia<br><input type="checkbox"/> Genital Herpes<br><input type="checkbox"/> Genital Warts<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> HPV<br><input type="checkbox"/> Other STD                                                                                                                                                                                                                                                                                                                                                             |
| <b>Endocrine</b><br><input type="checkbox"/> Adrenal Disorders<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Polycystic Ovary Syndrome (PCOS)<br><input type="checkbox"/> Thyroid Disorder                                                                                                         | <b>Neurological</b><br><input type="checkbox"/> Concussions<br><input type="checkbox"/> Convulsions/Seizures<br><input type="checkbox"/> Migraines/Severe Headaches<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Muscular Dystrophy<br><input type="checkbox"/> Stroke/TIA                                                                                                                | <b>Orthopedics</b><br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Fractures/Broken Bones                                                                                                                                              | <b>Surgical History</b><br><input type="checkbox"/> Appendectomy<br><input type="checkbox"/> Adenoidectomy<br><input type="checkbox"/> Ear Tubes<br><input type="checkbox"/> Gallbladder Removal<br><input type="checkbox"/> Knee ACL Repair L R<br><input type="checkbox"/> Knee Arthroscopy L R<br><input type="checkbox"/> Organ Transplant | <b>OB/GYN History</b><br><input type="checkbox"/> Endometriosis<br><input type="checkbox"/> Pregnancies #: _____<br><b>Exercise History</b><br><input type="checkbox"/> Lack of exercise<br><input type="checkbox"/> Exercising regularly<br>Moderate Exercising<br><i>Walking briskly, water aerobics, etc.</i><br><input type="checkbox"/> Less than 3 times per week<br><input type="checkbox"/> 3 or more times per week<br><b>Strenuous Exercising</b><br><i>Running, swimming laps, etc.</i><br><input type="checkbox"/> Less than 3 times per week<br><input type="checkbox"/> 3 or more times per week |
| <b>Kidney</b><br><input type="checkbox"/> Chronic Kidney or Bladder Disease<br><input type="checkbox"/> Kidney Stones                                                                                                                                                                                                 | <b>Mental Health</b><br><input type="checkbox"/> ADHD<br><input type="checkbox"/> Alcohol Abuse<br><input type="checkbox"/> Anorexia ( <i>Eating Disorder</i> )<br><input type="checkbox"/> Anxiety Disorder<br><input type="checkbox"/> Bulimia ( <i>Eating Disorder</i> )<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Drug Dependency<br><input type="checkbox"/> Other Mental Health Problems | <input type="checkbox"/> HIV Infection<br><input type="checkbox"/> Infectious Mononucleosis<br><input type="checkbox"/> Malaria<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Typhoid Fever     | <input type="checkbox"/> Ovarian Cyst Removal<br><input type="checkbox"/> Splenectomy<br><input type="checkbox"/> Tonsillectomy<br><input type="checkbox"/> Weight Loss Surgery<br><input type="checkbox"/> Other Prior Surgeries                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Ears/Eyes/Nose/Throat</b><br><input type="checkbox"/> Chronic Sinus Infections<br><input type="checkbox"/> Eye Disorders ( <i>other than glasses or contacts</i> )<br><input type="checkbox"/> Hearing Loss<br><input type="checkbox"/> Nasal Allergies/Hayfever                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Skin</b><br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Hives                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

☐ NO Significant Health Problems

List Medications

## Allergies

Have you ever had an allergic reaction? ☐ Yes ☒ NoMedication Allergies: NONEFood Allergies: NONEOther Allergies (latex, bee stings, etc.): NONE

## Other History

☐ Previous Hospitalizations NONE☐ OTHER Health Problems NONEDoes **YOUR IMMEDIATE FAMILY** have any of the following?☐ Adopted (Family history unknown)

|                                      | Mother | Father      | Siblings | Grandparents |
|--------------------------------------|--------|-------------|----------|--------------|
| Alcoholism                           |        |             |          |              |
| Blood Clots/Clotting Disorders       |        |             |          |              |
| <b>Cancer</b>                        |        |             |          |              |
| Breast                               |        |             |          |              |
| Colon                                |        |             |          |              |
| Melanoma                             |        |             |          |              |
| Other Cancers (List Type)            |        | <u>NONE</u> |          |              |
| Diabetes                             |        |             |          |              |
| Drug Dependency                      |        |             |          |              |
| Heart Disease                        |        |             |          |              |
| High Blood Pressure                  |        |             |          |              |
| High Cholesterol                     |        |             |          |              |
| Mental Illness                       |        |             |          |              |
| Stroke                               |        |             |          |              |
| Sudden Cardiac Arrest (under age 50) |        |             |          |              |
| Other (Please explain)               |        |             |          |              |
| Parent Deceased                      |        |             |          |              |

### What is your gender?

- ☐ Female  
☐ Male  
☐ Transgender  
☐ Other

### What is your sexual orientation?

- ☐ Heterosexual (Straight)  
☐ Gay or Lesbian  
☐ Bisexual  
☐ Other

### Abuse History

As violence is a problem in many families, we ask these questions to ALL patients.

- Verbal Abuse ☐ Yes ☒ No  
Physical Abuse ☐ Yes ☒ No  
Sexual Abuse ☐ Yes ☒ No

### Drug History

Do you take recreational drugs? ☐ Yes ☒ No

How much? \_\_\_\_\_ How often? \_\_\_\_\_ What type? Marijuana Cocaine Meth Heroin Spice Other \_\_\_\_\_

### Sexual History

Sexually active? ☐ Yes ☒ No ☒ Not currently

Partners ☐ Male ☐ Female ☐ Both

Birth Control/Protection - Please circle:

Abstinence Birth Control Pills Cervical Cap Condom Diaphragm Implant Injection IUD Patch

Post-menopausal Rhythm Spermicide Sponge Surgical Vaginal Condom Withdrawal Other *see comments* None

Last Menstrual Cycle 15 DEC Last PAP \_\_\_\_\_ Normal Abnormal (Circle)

Comments:

### Tobacco Use History

- ☐ Current every day  
☐ Current some days  
☐ Former smoker  
☐ Heavy tobacco smoker  
☐ Light tobacco smoker  
☒ Never smoker  
☐ Passive smoker - never smoked

Please circle:

Type used: Cigarettes Pipe Cigars Hookah E-cigs Chew

Packs/day: 0.25 0.5 1 1.5 2 3

Years: 0.5 1 2 2 4 5 10

### Alcohol Use History

- ☐ Current every day  
☐ Current some days  
☐ Former drinker  
☐ Heavy drinker  
☐ Social drinker  
☒ Never drinks

Please circle:

Type used: Beer Wine Liquor

Drinks/day: 0.25 0.5 1 1.5 2 3 4 5

Years: 0.5 1 2 2 4 5 10