# Travis C. Holcombe, M.D.,P.C.

**PRINT OUT AND FILL OUT COMPLETELY**

## Today's Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_Height:\_\_\_\_\_\_\_\_\_\_\_\_Weight:\_\_\_\_\_\_\_\_\_\_**

**PLEASE INDICATE IF YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING MEDICAL CONDITIONS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Asthma
 | * DVT, when
 | * Herpes
 | * Anxiety
 | * Sepsis
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| * COPD
 | * Stroke, when
 | * Tuberculosis
 | * Depression
 | * Personal or family history of malignant hyperthermia
 |
| * Sleep apnea Do you use a CPAP machine? ☐Yes
 | * Edema (swelling)
 | * MRSA
 | * PTSD
 | * Family history of DVT/PE
 |
| * Hypertension\*
 | * Vericose veins
 | * Hypothyroidsim
 | * Attempted suicide
 | * History of unexplained stillborn infant
 |
| * Coronary artery disease\*
 | * Anemia
 | * Diabetes
 | * Anorexia/bulimia
 | * 3 or more miscarraiges
 |
| * Congestive heart failure\*
 | * Hemophilia
 | * Obesity
 | * Alcoholism
 | * Melanoma, when stage
 |
| * Heart attack, when \*
 | * Hypercholesterolemia
 | * Osteoarthritis
 | * Dementia
 | * Non-melanoma skin cancer
 |
| * Pacemaker/Defibrillator\*
 | * Blood transfusion
 | * Rhematoid

Arthritis | * Delayed wound healing
 | * Prostate cancer
 |
| * Atrial Fibrillation\*
 | * Hepatitis C
 | * Gout
 | * Keloids
 | * Breast cancer
 |
| * Pulmonary embolism, when
 | * HIV/AIDS
 | * Fibromyalgia
 | * Cellulitis
 | * Organ transplant
 |

**\*Do you see a cardiologist? If yes, who**

**Please list any medical conditions you have that are not listed above**

**When was your last mammogram** Were the results normal ☐Yes ☐No, explain

## Social History:

Do you drink alcohol ☐No ☐Yes, how many drinks per week Smoke cigarettes ☐Never ☐Yes, how many per day ☐Former smoker, quit when Smoke Marijuana ☐Never ☐Yes, how much per day ☐Former smoker, quit when Do you use marijuana in any other form ☐No ☐Yes, form and frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you any illicit drugs ☐No ☐Yes, types and frequency Have you ever been treated for substance abuse ☐No ☐Yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any medication allergies** ☐No ☐Yes, please list medication allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Please list the medications (prescription and OTC) you take on a regular basis

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| --- | --- | --- | --- |
| **Medication List** | **Dosage** | **Frequency** | **Reason for Medication** |
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**If you take opioids (pain medication) on a regular basis, are you in a contract with a pain management specialist?** ☐No ☐Yes, managed by

**Past Surgeries Date**

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