# 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 |
| * 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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