LAPAROSCOPIC SURGERY NORTHWEST

MEDICAL/SOCIAL HISTORY

DATE_____

STICKER

REASON FOR CONSULTATION_____

PAST OR CURRENT ILLNESSES: (PLEASE CIRCLE)

High Blood Pressure	Cancer	Ulcers	Blood Disorders	Cholesterol
Asthma	Epilepsy	Depression/Anxiety	Hep-C/HIV	Heart Problems
Tumors	Rheumatic Fever	Diabetes (I or II)	Arthritis	Other

PREVIOUS MAJOR SURGERIES/HOSPITALIZATIONS: APPROX YEAR/NATURE OF PROBLEM OR N/A:

_____ _____

_____ _____

_____ _____

(PLEASE CIRCLE)

DO YOU HAVE ALLERGIES TO MEDICATION: YES / NO LIST_____

DO YOU TAKE COUMADIN OR OTHER BLOOD THINNERS: YES / NO DO YOU USE A CPAP MACHINE: YES / NO

HAVE YOU RECEIVED BLOOD: YES / NO DO YOU EXERCISE REGULARLY: YES / NO

ALCOHOL USE: YES / NO - DRINKS PER DAY _____ DRINKS PER WEEK _____ OCCASIONAL _____

IN RECOVERY _____ YEAR STOPPED _____

SMOKING: YES / NO / FORMER: CIGARETTES – PIPE – CHEW ETC:

PACKS PER DAY _____ HOW LONG_____ YEAR STOPPED: _____

DRUG USE: YES / NO /FORMER _____

IN RECOVERY: _____ YEAR STOPPED: _____

WHAT KIND OF WORK DO YOU DO?_____

WHO LIVES WITH YOU?_____

_

FAMILY HISTORY: ANY INHERITED DISORDERS OR PROBLEMS:

MOTHER: ALIVE / DECEASED PROBLEMS: _____

FATHER: ALIVE / DECEASED PROBLEMS: _____

PATIENT (PARENT/GUARDIAN) SIGNATURE: _____ DATE: _____

Your signature verifies that the above information is accurate and true.