

Medical Evaluation Preliminary

Patient Name _____ Today's Date _____

Sex _____ Age _____ Weight _____ Height _____ Occupation _____

1. What is the reason for your consultation? _____

If it is a lesion, where? _____

How long has it been present? _____

Are there any changes? _____

2. What is the history of your current problem? _____

3. Please list all prior surgeries that you have had and when: _____

For the following questions, please check Yes or No for all of the following answers

4. Do you have any trouble with your teeth? Yes ___ No ___

5. Do you have any eye problems? Yes ___ No ___

Blurry Vision? Yes ___ No ___

Eye Pain? Yes ___ No ___

Do you wear eyeglasses? Yes ___ No ___

Contacts? Yes ___ No ___

Prosthesis? Yes ___ No ___

6. Do you have any nose problems? Yes ___ No ___

Sinus problems? Yes ___ No ___

Do you have trouble breathing through your nose? Yes ___ No ___

7. Do you suffer any hearing loss? Yes ___ No ___

Ear problems? Yes ___ No ___

Do you use a hearing aid? Yes ___ No ___ Which ear? Right ___ Left ___

8. Do you have difficulty breathing at any time during the day or night? Yes ___ No ___

Do you have any lung problems? Yes ___ No ___

Asthma? Yes ___ No ___

9. Do you ever have chest pain? Yes ___ No ___

When you exert yourself? Yes ___ No ___

10. Do you have heart problems? Yes ___ No ___

Have you had heart surgery? Yes ___ No ___ When? Month ___ Day ___ Year ___

What was done? _____

Do you have Mitral Valve Prolapse (MVP) Yes ___ No ___

11. Do you have liver problems? Yes ___ No ___

Jaundice? (yellow skin color) Yes ___ No ___

12. Do you have stomach or intestinal problems? Yes ___ No ___

If yes, what? _____

13. Do you have kidney problems? Yes ___ No ___

Urinary problems? Yes ___ No ___

14. Reproductive problems? Yes ___ No ___

Last menstrual period Month ____ Day ____ Year ____

Number of pregnancies ____ Number of C-Sections ____

Have you had and breast problems? Yes ___ No ___

If yes, what are they? _____

Are you breast feeding? Yes ___ No ___

Bra Size _____

If you have had chemotherapy, when was your last dose? Month ___ Day ___ Year ___

15. Do you have joint, bone or muscle problems? Yes ___ No ___

Do you have a joint replacement? Yes ___ No ___

Do you have numbness in any part of your body? Yes ___ No ___

Please specify the location of this problem _____

16. Do you have back problems? Yes ___ No ___

Neck problems? Yes ___ No ___

17. Have you had skin cancer? Yes ___ No ___ If yes, where? _____

18. Have you had radiation therapy? Yes ___ No ___ If yes, where? _____

How often? _____

When was your last treatment? _____ How many treatments? _____

19. Do you have diabetes? Yes ___ No ___

If yes, how is it controlled? Diet ____ Oral Medications _____ Insulin _____

What kind and how much? _____

20. Do you have epilepsy, seizures, and/or convulsions? Yes ___ No ___

If yes, please list the medications that you take for this condition _____

21. Do you have high blood pressure? Yes ___ No ___ Low blood pressure? Yes ___ No ___

Have you had a stroke? Yes ___ No ___

Have you had frequent nose bleeds? Yes ___ No ___

22. Do you have depression? Yes ___ No ___

Nervous condition? Yes ___ No ___

What medication, if any, do you take for this? _____

23. Do you have a bleeding disorder? Yes ___ No ___

Do you bruise easily? Yes ___ No ___

Have you had or do you have circulatory problems? Yes ___ No ___

If yes, what are they? _____

24. Do you have thyroid problems? Yes ___ No ___

Hepatitis? Yes ___ No ___

Rheumatic Fever? Yes ___ No ___

25. Have you ever had any problems with anesthesia? Yes ___ No ___

Has your family ever had problems with anesthesia? Yes ___ No ___

26. Please list all medications you are currently taking: (please include over the counter medications, birth control pills and vitamins) _____

27. Do you have any allergies? Yes ___ No ___

Allergies to Medications? Yes ___ No ___

Seasonal? Yes ___ No ___

Food? Yes ___ No ___

28. What is your family medical history? (please list and illness or medical conditions)

Mother? _____

Father? _____

Brother? _____

Sister? _____

Grandparents? _____

29. Do you smoke cigarettes? Yes ___ No ___ Cigars? Yes ___ No ___ Other? Yes ___ No ___

Have you ever smoked? Yes ___ No ___ If yes, how much? _____ Packs per day

When was the last time you smoked? _____ (month/day/year)

30. Do you drink alcohol? Yes ___ No ___

If yes, how many _____ glass(es)/can(s)/cocktail(s) (circle one) per week ___ per month ___ per year ___

31. Have you or do you use recreational drugs? Yes ___ No ___

What kind and how much? _____

Is there anything else that the physician should know about? Yes ___ No ___

If yes, what? _____

I certify that I have given my complete medical history and that the omission or misrepresentation of any facts could influence the result of treatment or surgery.

Reviewed by:

Patient Signature: _____

Doctors Signature: _____

Date: _____

Date: _____