GARY R.SNIDER, MD **Medical History Form**

Patient: _____ Date of Birth: _____

Age: _____ Height:_____ Weight: _____

Reason for consultation: _____

Referred by:

HABITS

Smoker: ☐ No ☐ Yes amount: _____ Alcohol Use: ☐ No ☐ Yes amount: _____

Exercise: ☐ No ☐ Yes frequency/amount: _____

MEDICATIONS – Please list dose or number of pills per day)

Prescription & Non Prescription Drugs (Vitamins, Herbal Supplements)

_____

_____

Aspirin: ☐ No ☐Yes dose/frequency: _____

NSAIDs Use (Advil, Motrin, Naprosyn, etc):
☐ No ☐ Yes dose/frequency:_____

Steroids (Prednisone, Cortisone Injections, etc):
☐ No ☐ Yes Dose/frequency:_____

Diet Pills: (Herbal or prescription)
☐ No ☐ Yes dose/frequency:_____

ALLERGIES

☐ No ☐ Yes If yes please list:_____

PERSONAL PAST HISTORY – Have you ever had (check conditions that apply):

☐ Abnormal bleeding	☐ Irregular heart beat	☐ Thyroid disease	☐ Hepatitis
☐ Abnormal clotting	☐ Circulation problems	☐ TB/lung disease	☐ Depression
☐ Blood clots	☐ High blood pressure	☐ Bronchitis	☐ Mental illness
☐ Anemia	☐ Stroke	☐ Asthma	☐ Diabetes
☐ Angina/heart disease	☐ Fainting spells	☐ Emphysema	☐ Kidney disease
☐ Mitral valve prolapse	☐ Epilepsy/seizures	☐ Acid reflex/heart burn	☐ Glaucoma
☐ Chest pain	☐ Migraines/headache	☐ Intestinal ulcers	☐ Cancer, type: _____

Have you ever had a blood transfusion? ☐ No ☐ Yes Date: _____

Have you been tested for HIV? ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive

Have you ever been treated for a drug habit? ☐ No ☐ Yes Date: _____

Previous Surgeries (type of procedure and year): _____

_____

_____

_____

Other Hospitalizations (reason for hospitalization and year):

Other health problems? ☐ No ☐ Yes, please explain:

PCP:

ONCOLOGIST:

GENERAL SURGEON:

ANESTHESIA

Indicate types of anesthesia received in the past, and list any complications/reactions you experienced:

☐ Local anesthesia (complications/reactions): _____

☐ General anesthesia (complications/reactions): _____

☐ Spinal/Epidural (complications/reactions): _____

Have any family members had unusual reactions to anesthesia? ☐ No ☐ Yes, what: _____

FOR WOMEN ONLY

Number of pregnancies: _____ Number of children: _____

Date of last menstrual period:_____ Could you be pregnant? ☐ Yes ☐ No

Signature: _____WE WILL HAVE YOU SIGN IN PERSON_____ Date:_____

The answers I have given represent a true and complete history to the best of my knowledge.