Kettering Cardiothoracic and Vascular Surgeons, Inc.

Patient name: _____ DOB: _____ Date: _____

Circle Yes or No on each question:

Behavioral Health Problems:

ADD/ADHD	Y N
Anxiety	Y N
Bipolar disorder	Y N
Depression	Y N
Developmental delay	Y N
Postpartum depression	Y N
Psychosis	Y N
Schizophrenia	Y N

Cardiovascular/Blood:

Anemia	Y N
Angina	Y N
Arrhythmia	Y N
Bleeding/Bruising	Y N
Blood transfusion	Y N
Cardiomyopathy	Y N
Carotid stenosis	Y N
CHF	Y N
Clotting disorder	Y N
Coronary artery disease	Y N
Edema/Swelling	Y N
Heart murmur	Y N
HIV/AIDS	Y N
Hyperlipidemia	Y N
Hypertension	Y N
Myocardial infarction	Y N When:
PVD arm / leg	Y N
Rh incompatibility	Y N
Sickle cell anemia	Y N
Varicosities/Phlebitis	Y N

Endocrine/Oncology:

Addison's disease	Y N
Diabetes mellitus type I	Y N
Diabetes mellitus type II	Y N
Cancer Type:	Y N
Cushing syndrome	Y N
Obesity	Y N
Osteoporosis	Y N
Pancreatitis	Y N
Thyroid disease	Y N

Gastrointestinal:

Cirrhosis	Y N
Chronic constipation	Y N
Chronic diarrhea	Y N
Diverticulitis	Y N
GERD	Y N
GI ulcer	Y N
Hepatitis Type:	Y N
Hernia	Y N
Irritable bowel syndrome	Y N
Jaundice	Y N

Genitourinary:

Dialysis (Hemo)	Y N
Prostrate cancer	Y N
Kidney disease Doctor:	Y N
Kidney stones now / past	Y N
Nocturia (nightly urination)	Y N
Peritoneal dialysis	Y N
Polycystic kidney	Y N
Renal disorder	Y N
UTI now / past	Y N

Infection Disease History:

C-diff	Y N
Chicken pox	Y N
Herpes	Y N
MRSA	Y N
MUMPS	Y N
Rheumatic fever	Y N
Rubella	Y N
Measles	Y N
Shingles	Y N
STD	Y N
Tuberculosis	Y N
VRE	Y N
VRSA	Y N
Pertussis	Y N

Musculoskeletal/Skin:

Arthritis Type:	Y N
Osteoarthritis	Y N
Rashes/skin problems	Y N
Scoliosis	Y N
Trauma head/neck/jaw	Y N

Sensory/Neurological:

Alzheimer's	Y N
Headaches	Y N
Head injury	Y N
Memory loss	Y N
Paralysis	Y N
Peripheral neuropathy	Y N
Seizures	Y N
Stroke/TIA Symptoms:	Y N
Syncope Symptoms:	Y N

Respiratory:

Asthma	Y N
Chronic bronchitis	Y N
Chronic Cough	Y N
COPD	Y N
Dizzy with exertion	Y N
Emphysema	Y N
Home oxygen	Y N
Hypoxemia	Y N
Pneumonia	Y N
Sinus Problems	Y N
Shortness of breath	Y N
Sleep apnea CPAP?	Y N

Anesthesia History:

Difficult intubation	Y N
Malignant hyperthermia	Y N
PONV	Y N
Spinal Headache	Y N
Anesthesia complication	Y N
Pseudo cholinesterase Defic.	Y N
Esophageal dilatation	Y N

Surgical History:

AAA repair	Y N
Abdomen surgery	Y N
Appendectomy	Y N
Back surgery	Y N
Brain surgery	Y N
Bronchoscopy	Y N
Carotid endarterectomy	Y N
C-Section	Y N
Colon surgery	Y N
Cholecystectomy	Y N
Cystoscopy	Y N

Family History:	**Relationship:**
ADD/ ADHD	_____
Anemia	_____
Arthritis	_____
Asthma	_____
Cancer	_____
Clotting Disorder	_____
Diabetes	_____
Heart murmur	_____
Hypertension	_____
IBS	_____
Meningitis	_____
MRSA	_____
Heart attack	_____
Obesity	_____
Osteoporosis	_____
Pneumonia	_____
Scoliosis	_____
Sickle cell anemia	_____
Stroke	_____

Surgical History:

Fem-pop Bypass	Y N
Gastrectomy	Y N
Hernia repair	Y N
Hip surgery	Y N
Hysterectomy	Y N
IVC Filter	Y N
Knee surgery	Y N
Prostrate surgery	Y N
Small intestine surgery	Y N
Thyroid surgery	Y N
Upper GI endoscopy	Y N

Social History:

Alcohol use: (drinks per week)

_____ Glasses of wine

_____ Cans of beer

_____ Shots of liquor

_____Drinks containing .5 oz of alcohol

Sexually active: Y N

Birth Control/Protection: Circle

Abstinence	Patch
Colitis interuptus	
Condom	Post-menopausal
Diaphragm	Rhythm
Implant	Spermicide
Injections	Sponge
Inserts	Surgical
IUD	None
OCP	Other:
	_____

Drug use: (circle)

Marijuana Cocaine

Methamphetamines

Tobacco use: Y N

Packs/Day: _____

Years used: _____

Quit date: _____

Heart Surgery:

Coronary angioplasty(cath)	Y N
CABG When:	Y N
Pacemaker insertion	Y N Brand:
Heart surgery	Y N
ICD	Y N Brand:
PTCA / stent	Y N
Valve replacement	Y N

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Name: ______________________________ DOB: ____________ Date: ____________

Allergies: ____

Medication List (both prescribed and over-the-counter)

MEDICATION (Name of medication or generic)	**DOSAGE** (example-mg or number of tablets)	**FREQUENCY** (example-twice a day or at bedtime)