

Thank you for completing this form. This information will assist Dr. Fetter and staff in providing quality care.

NAME: _____ Ht. _____ Wt. _____ Age _____ Date _____

Medical History: Do you have or have you had:

| | | | | | | | | |
|-------------|-----------|----------|---------------|--|--------------------------|-----------|----------|---------------|
| <u>Lung</u> | | | <u>Family</u> | | <u>Vascular</u> | | | <u>Family</u> |
| Asthma | Yes _____ | No _____ | _____ | | Congestive Heart Failure | Yes _____ | No _____ | _____ |
| Bronchitis | Yes _____ | No _____ | _____ | | Heart Attack | Yes _____ | No _____ | _____ |
| Emphysema | Yes _____ | No _____ | _____ | | Heart Disease | Yes _____ | No _____ | _____ |
| Pneumonia | Yes _____ | No _____ | _____ | | High Blood Pressure | Yes _____ | No _____ | _____ |
| | | | | | Stroke | Yes _____ | No _____ | _____ |

| | | | | | | | | |
|-------------------|-----------|----------|---------------|--|--------------|-----------|----------|---------------|
| <u>Systemic</u> | | | <u>Family</u> | | <u>Other</u> | | | <u>Family</u> |
| Anemia | Yes _____ | No _____ | _____ | | Cancer | Yes _____ | No _____ | _____ |
| Bleeding Disorder | Yes _____ | No _____ | _____ | | Glaucoma | Yes _____ | No _____ | _____ |
| Clotting Disorder | Yes _____ | No _____ | _____ | | Hepatitis | Yes _____ | No _____ | _____ |
| Arthritis | Yes _____ | No _____ | _____ | | Seizures | Yes _____ | No _____ | _____ |
| Diabetes | Yes _____ | No _____ | _____ | | Thyroid | Yes _____ | No _____ | _____ |

Any other diseases, conditions, or problems we should know about?

Surgery History: List ALL prior operations (with years)-

Have you had problems with previous *anesthetics*? Yes _____ No _____
 If yes, what problem? _____

Has anyone in your family ever had a problem with an anesthetic? Yes _____ No _____

Social History:

Do you smoke? Yes _____ No _____ How many packs per day? _____ For how many years? _____
 Alcoholic beverage use? Yes _____ No _____

Medications: List medications you are currently taking including over-the-counter medicines or home remedies.

| DRUG NAME | STRENGTH | HOW OFTEN MEDICATION IS USED |
|-----------|----------|------------------------------|
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Allergies:

List all medications, food, and soaps you are allergic to (if no allergies, put "NONE"):

Are you sensitive to iodine or tape? Yes _____ No _____