Please answer Yes or No to each of the following.

Is there any family history of bleeding problems? Yes/No

Is there any family history of a bad reaction to general anesthetic? Yes/No

Do you have a history of:

Weight Loss	Y or N
Thyroid disease	Y or N
Trouble swallowing	Y or N
Abdominal Pain	Y or N
Nausea/vomiting	Y or N
Vomiting blood	Y or N
Diarrhea	Y or N
Constipation	Y or N
Change in bowel habits	Y or N
Blood in the stool	Y or N
Black stool	Y or N
Clay colored stool	Y or N
Bad reaction to general anesthetic	Y or N
Excessive/easy bleeding	Y or N
Temporary loss of vision in one eye	Y or N
Temporary weakness or numbness in one half of the body	Y or N
Temporary inability to talk	Y or n
Seizures	Y or N
Loss of consciousness/Fainting spells	Y or N
Chest pain (angina)	Y or N
Shortness of breath	Y or N
Irregular heart beat	Y or N
Ankle swelling	Y or N
Heart attack	Y or N
Heart failure	Y or N
Asthma	Y or N
Bronchitis	Y or N
Wheezing	Y or N
Pneumonia	Y or N
Chronic cough	Y or N
Coughing up blood	Y or N
Tuberculosis	Y or n
Difficulty urinating	Y or N
Blood in the urine	Y or N
Difficulty having or maintaining an erection (Males Only)	Y or N
Intravenous drug use	Y or N
Blood transfusions	Y or N
Varicose veins	Y or N
Phlebitis	Y or N
Exposure to AIDS	Y or N

Ht: _____

Wt:_____

SOUTH SOUND SURGICAL ASSOCIATES

Date _____

Your doctor will be able to provide better care for you if he is completely familiar with your medical history. Please take a few moments and answer the following questions as thoroughly as possible. The doctor will review the answers with you in more detail during your exam! Thank You!

Name: _____

Sex (circle) M or F

Date of Birth: _____

Give a brief description of current symptoms.

_____

List previous operations (include hospital, surgeon, year and reason for operation.)

_____

_____

List current medical illnesses (for example: diabetes, high blood pressure, heart disease etc.)

_____

_____

List current medications including dosage and frequency (for example: 10mg three times a day.

_____

_____

List all drug allergies.

_____

Describe current and past use of alcohol and tobacco products.

_____

List all significant illnesses and medical problems that have occurred in your immediate relatives.

_____

_____

PLEASE ANSWER ALL QUESTIONS ON THE NEXT PAGE. THANK YOU!!! (TURN OVER.)