Lee A. Kleiman, M.D., F.A.C.S.

Patient Name: ____ Date: _____________________

Past Medical History and General Health Problems: Please check off if you have had any of the following

[ ] Respiratory Disease/Asthma
[ ] Cancer, Type: _____________
[ ] Hypertension
[ ] Seizures
[ ] GI Disease
[ ] Psychiatric/Emotional
[ ] Arthritis
[ ] Diabetes Type 1 / Type 2
[ ] Stroke
[ ] Hepatitis/Liver Disease
[ ] Kidney Disease
[ ] Muscles/Joints
[ ] Bleeding Disorder
[ ] Cardiac Problems: ___________
[ ] Neurological
[ ] HIV, Infectious Disease
[ ]Autoimmune Disease
[ ] Other, please list: ____

Do you currently have an Advance Directive (for patients 65 and Over)? [ ] Yes [ ]No
If no, do you wish to name a surrogate decision maker? [ ] Yes [ ] No Name:___________________________________

Surgical History: Please provide any previous surgeries and when they occurred.

Social History: Occupation: ____

Marital Status (*please circle*) Single Married Divorced Widowed

Do you consume alcohol: NO YES How Often? ______________________________

Do you smoke cigarettes: NO YES For how long: ___________ Quit: _______

Do you consume caffeine: NO YES How much? _______________________________

Family History: Please circle the appropriate response and provide significant medical history such Diabetes, Heart Disease, Hypertension, Cancer, etc.

Father: Alive Deceased Medical History: ______________________________

Mother: Alive Deceased Medical History: ______________________________

Siblings: Alive Deceased Medical History: ______________________________

Alive Deceased Medical History: ______________________________

Alive Deceased Medical History: ______________________________

Any Family History of malignant hypo/hyperthermia? [ ]Yes [ ] No If so, who?______________________________

Review of Systems: Circle the symptoms you are most frequently experiencing.

Chest	Sinus	Nose	Throat	Eyes	Ears	Skin
Shortness of Breath	Infections	Sneezing	Sore	Itching	Itching	Itching
Wheezing	Pressure	Itching	Burning	Tearing	Drainage	Hives
Cough	Pain	Runny	Postnasal Drip	Swelling	Infections	Eczema
Chest Tight	Headaches	Congestion	Trouble Swallowing	Infections	Popping	Swollen lips, tongue, or face
Heartburn		Decreased smell or taste	Hoarseness	Pain	Pain	Psoriasis
		Bleeding	Gingivial Bleeding	Vision Change	Pressure	
			Clearing Throat	Double Vision	Decreased Hearing	
			Globus Sensation		Dysequilibrium	
					Vertigo	

Medication List: Please provide the name and dosage of any medications you take.

Name of Medication	Dosage

Allergies to Medications: ____

Latex Sensitivity: YES NO