

Check any of the following conditions which you have now or have ever had:

- | | | | | |
|---|--|---------------------------------------|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Cancer (Type) _____ |
| <input type="checkbox"/> Previous Transfusion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Colonoscopy (Year) _____ |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> STD | <input type="checkbox"/> Implant (Type) _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Dialysis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Blood Clots (Location) _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pace Maker/Defibrillator | <input type="checkbox"/> NONE |

Occupation _____

Tobacco Usage: Have you ever Smoked No Yes Packs per day _____ How long _____
 If you quit, when _____ Do you use smokeless tobacco No Yes

Alcohol consumption: No Yes

Have you or any family member been seen at Ozark Surgical Group before? No Yes

If yes please state who _____

Indicate family members with contributing illnesses such as heart disease, cancer, stroke, diabetes, vascular disease, etc.

RELATIONSHIP	DISEASE	PRESENT AGE	AGE AT DEATH	NONE
Father				
Mother				
Siblings				
Children/Aunt/Uncle.....				

List ANY and ALL past surgeries with dates and/or major medical problems (if no surgical history, please write "None")

PRESENT MEDICATIONS (If you take no medication, please write "None")

Medication	strength	how often taken	Medication	strength	how often taken
1 _____			6 _____		
2 _____			7 _____		
3 _____			8 _____		
4 _____			9 _____		
5 _____			10 _____		

Name of Pharmacy _____ Phone _____

ALLERGIES to MEDICINES OR MEDICAL PRODUCTS (SUCH AS X-RAY DYE OR LATEX). If you have no allergies, please write "None")

Family Physician _____ Referring Physician _____

Patient's Name _____ Birth Date _____ Today's Date _____