Wright Surgical Arts

PATIENT MEDICAL HISTORY

CONFIDENTIAL INFORMATION: Medical information will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge. The information you provide will be used by your doctor to make decisions regarding your care.

NAME:_____ AGE_____ HT_____ WT_____

REASON FOR VISIT_____DATE_____

REFERRAL SOURCE_____PRIMARY CARE PHYSICIAN_____

***SURGERY*: LIST THE NAMES AND YEAR OF ANY OPERATIONS YOU HAVE HAD: (INCLUDING COSMETIC SURGERY)**

_____

_____

HAVE YOU OR ANY FAMILY MEMBER EVER HAD AN ADVERSE REACTION TO ANESTHESIA?

NO YES IF SO, WHAT_____

DO YOU HAVE OR HAVE YOU EVER HAD: (PLEASE CIRCLE)

AIDS OR HIV	ASTHMA	BLEEDING TENDENCY	TB
BLOODTRANSFUSION	CANCER	CHEST PAIN	DIABETES
BRONCHITIS	EMOTIONAL PROBLEMS	EMPHYSEMA	EPILEPSY
DRY EYES	HEART DISEASE	HEART ATTACK	HEPATITIS
HIGH BLOOD PRESSURE	IRREGULAR HEARTBEAT	KIDNEY DISEASE	LIVER DISEASE
LUNG DISEASE	MITRAL VALVE PROLAPSE	STOMACH ULCER	STROKE

HAS ANY BLOOD RELATIVE HAD: (PLEASE CIRCLE)

BLEEDING TENDENCY BREAST CANCER HEART ATTACK HIGH FEVER AFTER SURGERY

SOCIAL HISTORY: (PLEASE CIRCLE)

ARE YOU A: NONSMOKER? SMOKER? EX-SMOKER? HOW MANY PACKS/DAY?_____

DO YOU USE A NICOTINE PATCH OR GUM? NO YES

DO YOU DRINK ALCOHOL, WINE, OR BEER? NO YES HOW MUCH PER WEEK?_____

WOMEN ONLY:

IS THERE ANY CHANCE YOU MAY BE PREGNANT? NO YES
NUMBER OF PREGNANCIES _____ LIVE BIRTHS _____ MISCARRIAGES_____

DATE OF LAST BREAST EXAM_____**RESULTS**_____

DATE OF LAST MAMMOGRAM_____**RESULTS**_____

_____ _____

PATIENT SIGNATURE **PHYSICANS SIGNATURE**