NEW YORK SURGICAL ARTS

PATIENT HEALTH HISTORY

Please answer all questions as accurately as possible.

Date: _____

NAME: _____
Last First M

PURPOSE FOR VISIT: What is the purpose of your visit today?

_____

_____

MEDICATIONS

Please list any medications ***including aspirin, vitamins, over-the-counter, or herbal medication***?

Medication Name	***Dose***	***How Often Taken***

ALLERGIES

Medication Name	***Type of Reaction***
Do you have environmental Allergies?	☐ **Yes** ☐ **No** Please list:
Do you have food Allergies?	☐ **Yes** ☐ **No** Please list:
Do you have a known allergy to Latex?	☐ **Yes** ☐ **No**

PAST MEDICAL HISTORY ***Have you ever been DIAGNOSED with any of the following conditions?***

	Yes	**No**	**Year**	**Comment**
CANCER (please list type):	❒	❒		
Diabetes:	❒	❒		
Cardiovascular				
Do you have a pacemaker	❒	❒		
High/Elevated Cholesterol	❒	❒		

High Blood Pressure	❒	❒		
Irregular Heart Beats	❒	❒		
Other Heart Problems	❒	❒		
Respiratory				
Asthma	❒	❒		
COPD	❒	❒		
Tuberculosis	❒	❒		
Sleep Apnea	❒	❒		

PAST MEDICAL HISTORY *Continued*

	Yes	No	Year	Comment
Gastrointestinal				
Hepatitis	❒	❒		
Reflux	❒	❒		
Stomach ulcers	❒	❒		
Kidney				
Kidney Failure	❒	❒		
Mental and Emotional				
Depression (requiring treatment)	❒	❒		
Anxiety (requiring treatment)	❒	❒		
Other	❒	❒		
Hematologic/Immunity				
Anemia	❒	❒		
HIV/AIDS	❒	❒		
Bleeding after surgery	❒	❒		
Blood clots in legs or lungs	❒	❒		
Blood transfusion	❒	❒		
Other Not Listed Above				
Problem:	❒	❒		

GYNECOLOGIC HISTORY *(Women, please complete the following)*

	Yes	No	Comment
Menses/Pregnancies/Births			
Are you pregnant?	❒	❒	
Date of last menstrual period:	___/____/___		
How many pregnancies have you had?	#_____		
How many live births have you had?	#_____		
Nursing			
Are you nursing?	❒	❒	
How many months total have you nursed?	#	months	
Hormone Replacement			
Have you ever taken Estrogen?	❒	❒	
Number of years taking Estrogen?	#	years	
Breast Health – Have you ever had:			
bloody nipple discharge?	❒	❒	
Non-bloody nipple discharge?	❒	❒	
Injury to breasts?	❒	❒	
Breast infections?	❒	❒	
Pain in breasts?	❒	❒	
Breast biopsy?	❒	❒	

PAST HOSPITALIZATIONS

Have you ever been hospitalized for a medical problem before? ☐**Yes** ☐**No** Please list below:

Year	Reason for Admission	Date	Physician

PREVIOUS SURGERIES:

Year	Procedure	Surgeon

ANESTHESIA HISTORY

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐**Yes** ☐**No**	If yes, please indicate which type of anesthesia and check reaction(s) below:	
	Reaction	
☐ General Anesthesia	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Difficult Intubation ☐ Other
☐ IV Sedation	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Other
☐ Epidural/Spinal	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Headache ☐ Other
☐ Regional Block	☐ No Problems	☐ Insufficient ☐ Prolonged ☐ Systemic Reaction ☐ Other
☐ Local	☐ No Problems	☐ Insufficient Block ☐ Heart Palpitations ☐ Systemic Reaction ☐ Other
Comments:		

FAMILY HISTORY ***Please mark all that apply:***

					Maternal		Paternal	
	Mother	**Father**	**Brother**	**Sister**	**Grandmother**	**Grandfather**	**Grandmother**	**Grandfather**
Specific Anesthesia problem	❒	❒	❒	❒	❒	❒	❒	❒
CANCER (please list type) under check mark	❒	❒	❒	❒	❒	❒	❒	❒
Cardiovascular:								
High Blood Pressure	❒	❒	❒	❒	❒	❒	❒	❒
Heart Problems	❒	❒	❒	❒	❒	❒	❒	❒
Respiratory:								
Asthma	❒	❒	❒	❒	❒	❒	❒	❒
Lung Cancer	❒	❒	❒	❒	❒	❒	❒	❒
Neurologic:								
Stroke	❒	❒	❒	❒	❒	❒	❒	❒
Hematologic								
Bleeding/clotting problem	❒	❒	❒	❒	❒	❒	❒	❒

SOCIAL HISTORY

Have you ever smoked?	☐**Yes**	☐**No**	Comments (indicate amount per day):
Do you smoke now?	☐**Yes**	☐**No**	
Do you drink alcohol?	☐**Yes**	☐**No**	Comments (indicate amount per week):
Do you use any recreational drugs?	☐**Yes**	☐**No**	Comments (indicate frequency):

NAME: _____

Signature: _____ **Date:**_____