

PORTLAND SURGEONS

If not enough room, please use back of form for notations

Name _____ Date of birth _____

Reason for office visit _____

1. Past medical history; please include chronic illness, medical conditions, mental health conditions, disabilities, and prior hospitalizations. (Month and year if possible):

2. Past surgical history; please include any surgery requiring general, spinal, epidural or local anesthesia. Include month and year. Females; please include C-sections:

3. If you have ever been diagnosed with cancer please list treatments with month and year:

4. Medications and dosages: Prescriptions, vitamins, herbs, aspirin, and over the counter medication

5. Have you ever taken blood thinners (Heparin, Coumadin, Lovenox, etc), if yes, state reason and dates _____

6. Allergies to medications? Please list medication and reactions or symptoms; this includes any adverse reactions to anesthesia _____

7. Personal History: If using any of the following, list quantity, how often used, and how long. If you have in the past used, please list stop date.

Tobacco _____

Alcohol _____

Recreational Drugs _____

8. Family History: List medical problems and ages of parents, brothers, sisters and children. If deceased, please list cause of death. List any major medical problems in the family.

9. Is there a family history of cancer? Please list type of cancer for parents, grandparents, siblings, aunts, uncles, and children.
