AGAVE SURGICAL ASSOCIATES, PC

Medical History

Patient Name: ____ DOB: ______________ Today's Date: _________________

REASON FOR VISIT: ____

Current and Past Medical History (please check all that apply)

- O Diabetes
  What type? __________
- O High Blood Pressure
- O Elevated Cholesterol
- O Kidney Disease
- O Heart Disease
- O CHF
- O Irregular Heartbeat
- O Atrial Fibrillation
- O Heart Attack
- O Pacemaker
  What brand? ____________________
- O Arthritis
- O Stroke
- O Phlebitis or Blood
- O Clots
- O Anemia/Blood Disorder
  What type? __________

- O GI Disorders
- O Diverticulitis
- O Stomach Ulcers
- O Ulcerative Colitis
- O Crohn's Disease
- O IBS
- O Lung Disease
- O Emphysema
- O COPD
- O Asthma
- O Tuberculosis
- O Valley Fever
- O Pneumonia
- O Glaucoma
- O Macular Degeneration
- O Cataracts
- O Legally Blind
- O Cancer
  What type? __________
  Date of Diagnosis: ____________________
  _

- O Mental Illness: ____________________
- O Anxiety
- O Depression
- O Epilepsy
- O Seizures

Vaccination dates:

- O Flu _____________
- O Pneumonia_______

Test dates:

- O Colonoscopy ____________________
- O Mammogram ____________________
- O EKG________________ _
- O Ever had a blood transfusion? Y N
- O Ever had General Anesthesia? Y N

Office use only:

Onset date:

Height

Weight

BP

Pulse

Pain

Have you had any prior surgeries? Please list below with dates.

Are you taking any medications? Please list below with strength and dosage or provide a list.

Are you allergic to any medications? Please list below.

Social History (Please circle yes or no)

AGAVE SURGICAL ASSOCIATES, PC

Medical History

Y N Current Smoker? How many years? _________________ Packs per day? _____________

Y N Former Smoker? When did you quit? ________________ How many years smoking? ______________

Y N Do you drink Caffeine? What type? __________________, __________________ How many per day? ___________

Y N Do you drink Alcohol? How many drinks per week? __________________ Type of alcohol? __________________