Agave Surgical Associates

Name_____ Date of Birth _____ Todays Date _____

REASON FOR VISIT _____

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

- ☐ Diabetes
  What type? _____
- ☐ High Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Kidney disease
- ☐ Heart Disease
- ☐ CHF
- ☐ Irregular heartbeat
- ☐ Atrial Fibrillation
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Arthritis
- ☐ Stroke
- ☐ Phlebitis or Blood Clots
- ☐ Lung Disease
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ Pneumonia
- ☐ Cancer
  What type?_____
  Date of Diagnosis_____
- ☐ GI Disorders
- ☐ Diverticulitis
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ IBS
- ☐ Anemia or Blood Disorders
  What type? _____
- ☐ Hepatitis
  What type?_____
- ☐ Thyroid Disease
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Legally Blind
- ☐ Mental Illness
  _____
- ☐ Anxiety
- ☐ Depression
- ☐ Epilepsy
- ☐ Seizures
- ☐ Ever had a Blood Transfusion?
  _____
- ☐ Ever had a General Anesthesia?
  _____
- ☐ Flu Vaccine_____
- ☐ Pneumonia Vaccine_____
- ☐ Colonoscopy_____
- ☐ Mammogram _____
- ☐ Flexible Sigmoidoscopy
- ☐ Fecal Occult Blood Test
- ☐ EKG

Have you ever had any prior surgeries? Please list below and include dates.

Are you taking any medications? Please list below and include dosages.

Are you allergic to any medications? Please list below.

Social History (Please answer yes or no to each question)

- ☐ Yes or No Current Smoker? For how many years? _____ How many packs a day?_____
- ☐ Yes or No Former Smoker? What year did you quit? _____How many years smoking?_____
- ☐ Yes or No Do you drink Caffeine? What type?_____, _____ How many per day?_____
- ☐ Yes or No Do you drink alcohol? How many drinks per week? _____ Type of Alcohol? _____
- ☐ Yes or No Have you ever used illegal drugs? Type_____
- ☐ Yes or No Are you currently using illegal drugs? Type_____