David Stoker, M.D.
Patient Medical History

DATE:____________________ Name:____

Age: ______________Height:______________Weight:_____________Sex:_____ Marital Status:_________________

Pharmacy and Physician Information:

Pharmacy Name:____Location:________________________________

Pharmacy Phone:____

Primary Care Physician____Telephone:____________________

Primary Care Physician's Address___________________________________ Last Seen:______________________

Other physicians you have seen in the last year:____

Previous Operations:

1.______________________________ Date:____________ 5.______________________________ Date:____________

2.______________________________ Date:____________ 6.______________________________ Date:____________

3.______________________________ Date:____________ 7.______________________________ Date:____________

4.______________________________ Date:____________ 8.______________________________ Date:____________

Medical Illnesses – Past or Current:

1.__________________________________ 4.____________________________ 7.____________________________

2.__________________________________ 5.____________________________ 8.____________________________

3.__________________________________ 6.____________________________ 9.____________________________

Have you ever had problems with anesthesia? ❑ Yes ❑ No **Malignant Hyperthermia?** ❑ Yes ❑ No

What was the nature of the problem?____

Has anyone in your family had problems with anesthesia? ❑ Yes ❑ No If yes, what problems?____________________

Drug Allergies:____

Are you allergic to Latex? ❑ Yes ❑ No **If yes, what is your reaction?**__________________________________

Prescription Medications:

1.____________________________ Dose:___________ 2. ___________________________ Dose:_____________

3.____________________________ Dose:___________ 4. ___________________________ Dose:_____________

5.____________________________ Dose:___________ 6.____________________________Dose:_____________

7.____________________________ Dose:___________ 8.____________________________Dose:_____________

What over-the-counter medications, vitamins or supplements are you taking?

____

____

Are you taking any diet or weight loss pills? ❑ Yes ❑ No If so, which ones?____________________________________

Do you smoke? ❑ Yes ❑ No How much? __________________________________ How many years? _______________

If you used to smoke, when did you quit?____

Do you drink alcohol? ❑ Yes ❑ No How much and what type?____

Family History - Have any immediate family members had the following? If yes, please indicate how you're related:

❑ Breast Cancer______________________ ❑ Blood Clots in the Veins of the legs_______________________________
❑ Melanoma_______________ ❑ High Blood Pressure____________ ❑ Bleeding Problems _______________________
❑ Stroke___________________________ ❑ Heart Disease____
❑ Cancer___________________________________ Type of Cancer?________________________________

Past Medical History – Have YOU ever had any of the following?

❑ Heart Disease ❑ Bleeding Disorders ❑ Psychiatric Disease
❑ Rheumatic Fever ❑ Asthma ❑ HIV+
❑ High Blood Pressure ❑ Tuberculosis ❑ MRSA Infections
❑ Mitral Valve Prolapse ❑ Arthritis ❑ Kidney Disease
❑ Diabetes ❑ Cancer Type? _______________ ❑ Blood Clots in your legs
❑ Stroke ❑ Hepatitis or Liver Disease ❑ Hernias
❑ Anemia ❑ Gastro Esophageal Disease ❑ Other:____

Review of Symptoms – Have YOU had any of the following symptoms in the past five years?

❑ Weight Change ❑ Bleeding Problems ❑ Jaundice
❑ Dry eyes ❑ Easy Bruising ❑ Depression
❑ Chronic Cough ❑ Swelling of Feet or Ankles ❑ Passing out or Fainting
❑ Shortness of Breath ❑ Skin Rash ❑ Seizures
❑ Wheezing ❑ Skin Infections ❑ Swollen Lymph Nodes (glands)
❑ Chest Pain ❑ Chronic Constipation ❑ Joint or Muscle Pain
❑ Irregular Heart Beat ❑ Heart Burn ❑ Anxiety
❑ Low Blood Pressure ❑ Problems with Urination ❑ Other:____

Women Only:

Date of Last Menstrual Period:_________________________

Date of Last Mammogram:_____________________________ Was it Normal? ❑ Yes ❑ No

Have you ever had an Abnormal Mammogram? ❑ Yes ❑ No If so, what were the results:______________________

Have you ever had a breast biopsy? ❑ Yes ❑ No If so, what were the results:______________________

Number of pregnancies_____________________________ Number of births_____________________________________

I attest that the health history as noted above is complete and accurate. All prescribed medicines and over the counter supplements and vitamins are listed. I understand that omissions or misrepresentations may affect my personal health, safety and/or the outcome of any of my procedures.

Signature:____ Date: _________________________________