A.W. PERRY, JR., M.D., A.M.C.

Medical History

Please Print

Name: _____Age: _____ Height: _____ Weight: _____

LIST ALL PREVIOUS SURGERIES: **Year**

_____ _____
_____ _____
_____ _____
_____ _____

DO YOU HAVE A HISTORY OF: **Circle** **Yes or No**

Abnormal bleeding _____ Yes No
Angina_____ Yes No
Asthma_____ Yes No
Black Stools_____ Yes No
Bleeding Disorders_____ Yes No
Cancer_____ Yes No
Deep Vein Thrombosis_____ Yes No
Diabetes_____ Yes No
Heart Attack (Myocardial Infarction)_____ Yes No
Hepatitis (Jaundice)_____ Yes No
HIV Infection (Positive)_____ Yes No
Hypertension (High Blood Pressure)_____ Yes No
Irregular Heartbeat_____ Yes No
IV Drug Use_____ Yes No
Mitral Valve Prolapse_____ Yes No
Nervous Breakdown_____ Yes No
Psychiatric Care_____ Yes No
Pulmonary Embolus_____ Yes No
Rheumatic Fever_____ Yes No
Stroke_____ Yes No
Thyroid Disease_____ Yes No
Tuberculosis (TB)_____ Yes No
Other_____ Yes No
Do you or a family member have a
History of Malignant Hyperthermia?_____ Yes No

IN THE LAST SIX MONTHS HAVE YOU TAKEN:

Accutane_____ Yes No
Anticoagulants (Blood Thinning Medications)___ Yes No
Antidepressant Medication_____ Yes No
Antihypertensive Medication_____ Yes No
Steroids (Prednisone, cortisone, etc.)_____ Yes No
Aspirin or other Anti-inflammatory Meds____ Yes No

DATE OF LAST PHYSICAL EXAM:_____
BY WHOM:_____
DATE OF LAST ECG:_____
DATE OF LAST CHEST X-RAY:_____

LIST ALL CURRENT MEDICATIONS:

_____
_____
_____
_____

LIST ALL HERBAL SUPPLEMENTS AND HOMEOPATHIC TREATMENTS:

_____
_____
_____

LIST DRUG ALLERGIES AND ANYTHING ELSE YOU HAVE HAD AN ADVERSE REACTION TO:

Medications

Anesthetic Agents_____ Yes No
Antibiotics_____ Yes No
Pain Medications_____ Yes No
Other Medications_____ Yes No

Other

Eggs_____ Yes No
Iodine_____ Yes No
Latex_____ Yes No
Seafood_____ Yes No
Tape_____ Yes No
Other_____ Yes No

DO YOU SMOKE?_____ Yes No
Packs or cigarettes per day? _____

ALCOHOL CONSUMPTION:
Amount per week?_____

NAME AND ADDRESS OF PRIMARY PHYSICIAN:

_____
_____
_____

FEMALE PATIENTS ONLY:

Date of last menstrual cycle_____
Date of last mammogram_____
Number of children_____
Number of pregnancies_____
Are you pregnant?_____Yes No
Family history of breast cancer_____Yes No
Your relationship to above_____
_____

I understand that the above answers are important and may affect my safety during and after surgery. I certify that all of the above answers are completely true and correct to the best of my knowledge.

Signature _____ **Date** _____