ROBERT J. SPIES, M.D. PC
PRE-OPERATIVE HISTORY FORM

PLEASE PRINT

NAME: _____DATE: _____

PAST OPERATIONS:

NONE_____. (Or list any past operations with the approximate date, age at the time of the operation, and the name of the physician and facility. {Include minor operations such as tonsillectomy, hemorroidectomy, etc.}.)

DDDD

DATE:	AGE:	OPERATIONS:	PHYSICIAN/FACILITY

ACCIDENTS:
List any serious type of injuries with the approximate date, your age, type of injury, and the name of the physician and hospital. {Include burns, nasal fracture or trauma, serious lacerations, etc.}

DATE:	AGE:	TYPE OF INJURY:	PHYSICIAN/FACILITY

PAST ILLNESSES:

AGE:	ILLNESS:

CHILDHOOD DISEASES:

_____CHICKEN POX _____MEASLES/MUMPS _____RHEUMATIC FEVER _____DIPTHERIA

Other: (specify)_____

ALLERGIES:
NO KNOWN ALLERGIES: _____
Please check any medications(s) which your are allergic to:

____Aspirin	____Lidocaine	____Percodan
____Cocaine	____Marcaine	____Sulfa
____Codeine	____Morphine	____Tetracycline
____Demerol	____Neosporin Ointment	____Tylenol
____Erythromycin	____Penicillin	____Valium
____Ketamine	____Percocet	____Vicodin

Other medication (specify)_____

ARE YOU ALLERGIC TO:

____Adhesive Tape	____Iodine	____Latex

MEDICATIONS YOU ARE PRESENTLY TAKING:

MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBED BY

DO YOU USE TOBACCO PRODUCTS? ____NO ____YES If cigarettes, how many packs a day: _____

HEIGHT:_____ WEIGHT:_____
(FOR WOMEN ONLY) Do you take Estrogens (creams, shots, pills) or birth control pills? _____
Please specify:_____

FAMILY HISTORY: If ANY of the following run in your family please check and **specify which family member.**

____Allergies _____ ____Heart Disease _____

____Cancer _____ ____Strokes _____

____Diabetes _____ ____Tuberculosis _____

PRE-OPERATIVE SCREENING:

____Adverse effect to any anesthetic (If so please specify)_____

____Angina	____Asthma	____Easy Bruising Tendency
____Blood Clots in Legs	____Frequent Pneumonia	____Prolonged Bleeding
____Heart Attack	____Diabetes	____Recurrent Infections
____Pacemaker (cardiac)	____Hepatitis	____Poor Wound Healing
____Pulmonary Embolism	____Jaundice (skins turns yellow)	____Keloids
____Stroke	____High Blood Pressure	____Heart Rhythm Disturbances
____Congestive Heart Failure	____Bronchitis	____Blood Disorder
____Cancer		

REVIEW OF SYSTEMS: Please check the appropriate squares in the following list of symptoms. (If you are having or have had the symptoms in the last six months).

HEAD & NECK SYMPTOMS

____Severe Headaches	____Severe Hearing Loss	____Toothache at present
____Dizzy Spells	____Ringing in Ears	____Chronic Sore Tongue
____Failing Vision	____Discharge from Ears	____Persistent Sore Gums
____Eye Pain	____Repeated Nosebleeds	____Prolonged Hoarseness
____Double Vision	____Chronic Nose Obstructions	____Persistent Neck Rigidity
____See “Floating Lights”	____Pain in Ears	____Swelling in Neck

HEART & LUNG SYMPTOMS

____Chest Pain on Effort	____Sit up to breath easily	____Night sweats
____Skipping Heart Beats	____Chronic Cough	____Ankles Swollen
____Difficulty breathing	____Spit up Blood	____Any Heart Defects

STOMACH & INTESTINAL SYMPTOMS

____Chronic Abdominal Pain	____Vomit Blood	____Clay Colored Stools
____Persistent Nausea	____Chronic Diarrhea	____Habitual Constipation
____Heartburn	____Black Tarry Stools	____Hemorrhoids
____Appetite Loss	____Blood from rectum	____Recurrent Vomiting

URINARY & MENSTRUAL SYMPTOMS **(for women only)**

____Excess Urination
____Urinary Shutdown
____Scanty Urination
____Blood in Urine
____Excessive night urination
____Pain with Urination
____Leakage of Urine
____Passed any stones
____Bedwetting
____Retention of Urine
____Excess Menstruation
____Painful Menstruation
____Bleed between periods
____Missed periods
____Pelvic infections

NERVE MUSCLE & JOINT SYMPTOMS

____Numbness
____Disturbance in walking
____Tingling Sensations
____Muscle jerking
____Paralysis
____Recurrent Muscle Cramps
____Shaking
____Joint Trouble
____Nervous Breakdown
____Unusual Stress
____Memory Loss
____Personality Changes
____Speech Disturbances
____Seizures
____Drug Problems
____Alcohol Problems
____Mental Problems
____Blackout Spells

Are there any additional health factors in your history which have not been covered in this medical history form?
_____(If yes, please use the following space for additional comments.)

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