Agave Surgical Associates

Name ______________________ **Birth Date** ____________ **Today's Date** __________

REASON FOR VISIT ____

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

☐ **Diabetes**
Date of diagnosis ________

☐ **High Blood Pressure**

☐ **Elevated Cholesterol**

☐ **Kidney Disorders**

☐ **Heart Disease**
☐ **CHF**
☐ **Irregular heartbeat**
☐ **Atrial Fibrillation**
☐ **Pacemaker/AICD**
☐ **Heart Attack**

☐ **Arthritis**

☐ **Stroke**
Date ______________
Any paralysis or deficit?
____

☐ **Phlebitis or Blood Clots**

☐ **Lung Disease**
☐ **Emphysema**
☐ **COPD**
☐ **Asthma**
☐ **Tuberculosis**

☐ **Valley Fever**
☐ **Pneumonia**

☐ **Cancer**
Date of diagnosis ________
Type ______________

☐ **GI Disorders**
☐ **Diverticulitis**
☐ **Stomach Ulcers**
☐ **Ulcerative Colitis**
☐ **Crohn's Disease**
☐ **IBS**

☐ **Anemia or Blood Disorders**
Type ______________

☐ **Hepatitis**
Date of Diagnosis ________
Type ______________

☐ **Thyroid Disease**
☐ **Hyperthyroid**
☐ **Hypothyroid**

☐ **Glaucoma**
☐ **Macular Degeneration**
☐ **Cataracts**
☐ **Legally Blind**

☐ **Mental Illness**
Type ______________

☐ **Epilepsy or Seizures**

☐ **Ever had a Blood Transfusion?**
Did you have any reaction?
____

☐ **Ever had General Anesthesia?**
Did you have any problems?
____

☐ **Flu Shot**
Date ______________
☐ **Pneumonia Vaccine**
Date ______________
☐ **Colonoscopy**
Date ______________
☐ **Mammogram**
Date ______________

☐ **Flexible Sigmoidoscopy**
Date ______________
☐ **Fecal Occult Blood Test**
Date ______________
☐ **EKG**
Date ______________

Have you 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?** How many packs a day? ________ For how many years ?__________

☐ **Yes** or ☐ **No** **Former smoker?** How many years? __________ What year did you quit? ________

☐ **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 ______________________