Agave Surgical Specialists

GENERAL, WEIGHT LOSS & MINIMALLY INVASIVE SURGERY

PATIENT MEDICAL INFORMATION

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 ____________