# Office of Anna Drzewiecki, M.D.

**Today's Date:** MM _____ DD_____ YYYY _____

Last Name: _____ First: _____ Middle: _____

Date of Birth: MM _____ DD_____ YYYY_____ Weight: _____ Height: _____

Primary Care Physician: _____

## Medical Information

**A.** List all medications you are currently taking or have recently taken. Include the dose and frequency (once a day, etc.) Be sure to include aspirin, blood thinners, cortisone and over-the-counter drugs. If you need more room, please add to section E.

| | Medications | Reason | Dose | When Taken |
|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ | _____ |

**B.** List any allergies to drugs, food or latex. _____

**C.** List all previous surgeries, including any child birth. If you need more room, please add to section E.

| | Previous Surgery | Year | Anesthesia Type | Any reaction: |
|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |

4. _____ _____ _____ _____

5. _____ _____ _____ _____

6. _____ _____ _____ _____

7. _____ _____ _____ _____

**D.** Do you have a history of any of the following? If "Yes", then provide any additional information on line or in "E".

Yes □ No □ 1. □ Stroke □ seizures □ migraines □ motion sickness _____

Yes □ No □ 2. □ High blood pressure □ heart attack □ murmur □ chest pain □ irregular heart beat
□ rheumatic fever _____

Yes □ No □ 3. □ Prolapsed mitral valve □ Take antibiotics for dental procedures: _____

Yes □ No □ 4. □ Asthma □ emphysema □ TB □ positive TB skin test _____

Yes □ No □ 5. □ Recent cold □ persistent cough □ Sleep apnea _____

Yes □ No □ 6. □ smoked in the past. Quit when _____
□ presently smoke cigarettes. Packs per day _____ per week_____

Yes □ No □ 7. □ Kidney stones □ renal failure? _____

Yes □ No □ 8. □ Hepatitis □ jaundice □ liver problems _____

Yes □ No □ 9. Diabetes – □ diet controlled □ oral medications □ insulin controlled_____

Yes □ No □ 10. □ Bleeding disorders □ hemophilia □ sickle cell □ family history of bleeding disorders

Yes □ No □ 11. □ Personal History of □ deep venous thrombosis □ pulmonary emboli □ Family history of either

Yes □ No □ 12. Problems with □ back □ neck □ muscles _____

Yes □ No □ 13. □ Hiatal hernia □ frequent heartburn □ ulcers □ indigestion _____

Yes □ No □ 14. Any family members with bad reaction to anesthesia? _____

Yes □ No □ 15. Alcohol consumption? Amount (daily, weekly or monthly): _____

Yes □ No □ 16. Drug use □ marijuana □ cocaine □ heroin _____

Yes □ No □ 17. □ Herpes □ HIV+ □ other infectious disease _____

Yes □ No □ 18. Are you pregnant? Due date: MM _____ DD _____YYYY_____

Yes □ No □ 19. Other medical history: _____

_____

**E.** Additional information:

_____

_____

_____

*The above information is correct to the best of my knowledge.*

Patient Signature: _____

Print Name: _____ Date: MM_____ DD_____ YYYY_____