Patient Label

Health History

Date of last Physical Exam: _____

Name of primary care physician: _____ Office Phone number: _____-_____-_____

Address: _____ City:_____State:_____ Zip: _____

Chief Complaint or area of concern (s):

_____

Procedure to be performed:_____

Past Medical History:

Heart Disease _____	Hypertension _____	Diabetes: _____
Asthma: _____	Seizures: _____	Hepatitis: _____
Hypo/Hyper thyroid: _____	Heart Murmur: _____	Rheumatic Fever: _____
HIV/AIDS: _____	Malignant Hyperthermia: _____	Cancer: _____
Myasthenia Gravis: _____	Cold sore/Fever blisters: _____	Other, specify: _____

List any previous surgery or hospitalizations and approximate dates:

_____

_____

Current Medications: Please list ALL medications you are taking, prescribed or over the counter (including any natural supplements) and the reason you are taking them:

_____

_____

Do you have any DRUG ALLERGIES: _____ NO _____YES, if so please indicate drug and reaction to drug:

_____

Please list any other allergies and the reaction you have experienced in the past:_____

_____

MIAMI SUNSET
Surgery Center

Patient Label

Health History

(continue)

Social History:

Do you smoke? (circle): YES NO If YES, how much:_____

If you smoked previously, when did you quit? _____

Do you drink? (circle): YES NO If YES, how much:_____

_____Daily _____Weekly _____Weekends _____Occasionally

Review of Systems: Please indicate if you are experiencing any of the following symptoms:

Hearing Difficulty: _____	Blurred Vision: _____	Nosebleeds:_____
Difficulty swallowing:_____	Coughing Blood: _____	Chronic Cough: _____
Shortness of breath: _____	Chest pain: _____	Nausea: _____
Vomiting: _____	Blood in stool/urine: _____	Swelling: _____
Joint pain/stiffness: _____	Painful urination: _____	Fainting spells: _____

Women Only:

Are you pregnant (circle) : YES NO Are you taking birth control pills: YES NO

Are you nursing (circle): YES NO Do you have menstrual problems: YES NO

A urine pregnancy test is required– Do you have any objections to the test: YES NO

Signature of Patient;_____ Date/Time: _____

Reviewed by physician (signature):_____Date/ Time: _____