DO NOT MAIL IN!!

BRING TO OUTPATIENT ON CONSULT DATE

NAME: ______________________________ DATE: ______________

HEIGHT: ____________ WEIGHT: ______________ AGE: ____________

REASON FOR ADMISSION/PROCEDURE: ______________________________

LIST ANY PREVIOUS SURGERIES & APPROXIMATE DATES: ______________________________

____

____

LIST ANY MEDICATIONS CURRENTLY TAKING (dosage, strength, and how often) Include herbal and over the counter medications,

1) ____________ 6) ____________
2) ____________ 7) ____________
3) ____________ 8) ____________
4) ____________ 9) ____________
5) ____________ 10) ____________

LIST ANY ALLERGIES (food, drug, or latex)

1) ____________ 5) ____________
2) ____________ 6) ____________
3) ____________ 7) ____________
4) ____________ 8) ____________

CIRCLE BELOW IF YOU HAVE OR HAVE EVER HAD:

RESPIRATORY SYSTEM

1) Asthma / Wheezing
2) Emphysema
3) Bronchitis
4) Shortness of breath
5) Cough
6) Smoke? Yes / No How many years? ____________
7) Packs per day
8) Lung surgery
9) Collapsed lung
10) Date of last chest x-ray
11) Do you currently have a cold? Yes / No
12) TB
13) Other ______________________________

CIRCULATORY SYSTEM

1) Heart Attack
2) Angina or Chest pain
3) Heart failure
4) Heart surgery
5) Irregular heart beat
6) Mitral valve prolapse
7) Rheumatic fever
8) Date of last EKG ____________________
9) Surgery on blood vessels (Carotid, Aorta, Leg vessels, etc.)
10) Heart murmur
11) High blood pressure
12) Other ______________________________

CENTRAL NERVOUS SYSTEM

1) Stroke
2) Paralysis
3) Seizures / Epilepsy
4) Weakness of arm or leg
5) Surgery on spine or back
6) Motion sickness
7) Spinal cord injury
8) Black-out spells
9) Mental Illness
10) Other ______________________________

HAVE YOU HAD OR DO YOU HAVE:

1) Liver problems (Cirrhosis, Hepatitis, Jaundice)
2) Kidney problems
3) Diabetes
4) Thyroid disease
5) Sickle cell disease
6) Reflux of food od Hiatal hernia
7) Do you drink alcohol? Yes / No How much?
8) Joint prosthesis
9) Known AIDS antibody
10) Problems with blood clotting Yes / No
11) Cancer
12) Chemotherapy or Radiation therapy

THIS AREA TO BE COMPLETED BY HOSPITAL STAFF.

REVIEWED BY: ______________________________ **DATE:** ______________

Patient/Significant Other: ______________________________

Valdosta, GA

94203485

PATIENT INFORMATION SHEET