Jerome Lamb, M.D., P.C.
HEALTH QUESTIONNAIRE

NAME____BIRTHDATE __________ AGE_________________

ADDRESS_______________________________________ CITY, STATE, ZIP____

TODAY'S DATE_________________HOME PHONE # ______________________ WORK PHONE #______________________

Referring Physician______________________________ Do you have an Advance Directive or Living Will? Yes______ No______

If no, would you like information about an Advance Directive? Yes_____ No_____

Advance Directive Information given on_____________ by ___________________________

Past Medical History:

List any conditions that you are currently under treatment for.

____

____

List any inactive/past medical problems.

____

____

List any prior surgeries.

____ date or age ______________________

____ date or age ______________________

____ date or age ______________________

Social History:

Circle One: Single Married Separated Divorced Widowed

Occupation ____

With whom do you live?____

Do you smoke? Yes No If so, how many years? __________________ Packs a day? _____________

How much alcohol do you consume in a week (in drinks)?____

HIV Exposure: Are you a member of a high risk group for HIV (AIDS) infection? Yes No
--ex. homosexual, hemophiliac, IV drug use, transfusion--

Have you ever been tested for HIV? Yes No

Hepatitis Exposure: I have been immunized against Hep B Yes No

Have you been tested for Hepatitis C Yes No

Family History:

Is there any history of anesthetic reaction in your family? Yes No

List any significant diseases which run in your family.

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____

Systems Review: Do you have any of the following?

Circle One: Right-handed Left-handed

Height ________________ Weight ________________

Skin:
- Unexplained skin lesions .... No Yes
- Recurrent blisters or colds sores .... No Yes
- Frequent infections .... No Yes

Eyes-Ears-Nose-Throat:
- Glaucoma .... No Yes
- Double vision .... No Yes
- Dry eyes .... No Yes
- Frequent sneezing .... No Yes
- Motion Sickness .... No Yes
- Perforated ear drum .... No Yes
- Deafness .... No Yes
- Neck stiffness .... No Yes
- Thyroid abnormality .... No Yes

Respiratory:
- Chronic bronchitis .... No Yes
- Bloody cough .... No Yes
- Asthma .... No Yes
- Emphysema .... No Yes

Cardiac:
- History of heart attack/Open Heart Surgery .. No Yes
- Irregular heartbeat .... No Yes
- Chest pains .... No Yes
- Shortness of breath with walking or laying down .... No Yes
- High blood pressure .... No Yes

Gastrointestinal:
- Ulcer disease .... No Yes
- Vomiting blood .... No Yes
- Liver disease .... No Yes
- History of hepatitis A, B or C .... No Yes
- Bloody or black stools .... No Yes
- Heartburn .... No Yes

Genitourinary:
- Burning or pain on urination .... No Yes
- Frequent urination .... No Yes
- History of kidney stones .... No Yes

Gynecological: (women only)
- Number of pregnancies_____Number of deliveries__
- Is there any chance you are pregnant .... No Yes

Neurologic:
- History of seizures .... No Yes
- History of MS or Myasthenia .... No Yes
  (muscle weakness)

Hematologic:
- History of anemia .... No Yes
- History of excessive bleeding .... No Yes

Endocrine:
- Thyroid disease .... No Yes
- Diabetes .... No Yes

Drug allergy or sensitivity: Yes No

List any. ________________________ What reaction did you have? ____________

________________________ What reaction did you have? ____________

________________________ What reaction did you have? ____________

Current medications:

List any prescribed medications (including dosage and intervals).

________________________ ________________________

________________________ ________________________

List any over-the-counter medication you take (including how often).

________________________ ________________________

________________________ ________________________

Date of last Aspirin or NSAID (Motrin, Aleve) taken.________________________

(Aspirin, Aspirin containing over-the-counter medications, Celebrex, Ibuprofen, Naprosyn and other NSAID's should not be taken for 10 days prior to and 5 days following surgery. Taking tylenol should not have an effect on your surgery).Coumadin is prohibited for five days prior to surgery. Cross check any medications, herbs and supplements against your provided list of prohibited substances and/or check them over the internet for platelet inhibition or increased risk of bleeding.

________________________ ________________________

Signature of patient or person completing this form — Relationship (if other than patient)