PATTI FLINT, M.D., FACS, P.C. **(480) 945-3300**

8129 N. 87th Place Suite 200, Scottsdale, AZ 85258

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Marital Status:	Sex: _____ Weight: lbs
What surgery are you considering?			Height: ft in

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Mitral Valve Prolapse	Yes	No	Stomach Ulcers	Yes	No
Anemia	Yes	No	Frequent Heartburn	Yes	No
Blood Pressure Abnormalities	Yes	No	Gastritis	Yes	No
Chest Pain/Angina	Yes	No	Colitis	Yes	No
Heart Attack	Yes	No	Problem Constipation	Yes	No
Irregular Heartbeats	Yes	No	Vomiting Blood	Yes	No
Congestive Heart Failure	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Heart Murmurs	Yes	No	Hemorrhoids	Yes	No
Heart Block	Yes	No	Kidney Disease/Stones	Yes	No
Low Potassium	Yes	No	Frequent Bladder Infections	Yes	No
Abnormal EKG	Yes	No	Prostate Problems	Yes	No
Pacemaker	Yes	No	Skin Disorders	Yes	No
Any Heart Disease	Yes	No	Rashes	Yes	No
Sickle Cell Anemia	Yes	No	Skin Cancer	Yes	No
Bronchitis	Yes	No	Keloids	Yes	No
Emphysema	Yes	No	Steriod Medicaions	Yes	No
Pneumonia	Yes	No	Frequent Boils	Yes	No
Asthma	Yes	No	Cold Sores/Fever Blisters	Yes	No
Wheezing	Yes	No	Stroke	Yes	No
Tuberculosis	Yes	No	Epilepsy	Yes	No
Chronic Cough	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Abnormal Chest X-Ray	Yes	No	Black outs	Yes	No
Major Allergies	Yes	No	Diabetes	Yes	No
Chronic Sinus Problems	Yes	No	Recent Unexpected Weight Loss/Gain	Yes	No
Any Lung Disease	Yes	No	Night Sweats/Fever	Yes	No
Blood Clots in your legs	Yes	No	Airway Obstruction (Nasal)	Yes	No
Pulmonary Embolism	Yes	No	Glaucoma	Yes	No
Phlebits	Yes	No	Loss of Vision	Yes	No
Varicose Veins	Yes	No	Radial Keratotomy	Yes	No
Tendency to Bleed Easily	Yes	No	Wear Glasses/Contacts	Yes	No
Bruise Easy	Yes	No	Arthritis	Yes	No
Blood Clotting Abnormalities	Yes	No	Bone, Joint, Muscle Problems	Yes	No
Blood or Plasma Transfusions	Yes	No	Chronic Neck Pain	Yes	No
Hemophilia	Yes	No	Chronic Back Pain	Yes	No
Recurrent Nose Bleeds	Yes	No	Emotional Problems	Yes	No
Liver Disease	Yes	No	Aids or HIV Virus	Yes	No
Jaundice or Hepatitis	Yes	No	Alcoholism or Drug Dependency	Yes	No

FAMILY HISTORY: Please check all that apply

____Breast Cancer ____Turberculosis ____Epilepsy ____Stroke ____Heart Disease ____Cancer_____

____Bleeding Disorders ____Diabetes ____Asthma ____Lung Disease ____Kidney Disease

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

_____

_____

_____

2. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____

3. Do you react abnormally to any medication? ❒ Yes ❒ No Which? _____

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

❒ Yes ❒ No If yes, when and where? _____

5. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? _____

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

❒ Yes ❒ No If so, how much? _____

7. Do you smoke? ❒ Yes ❒ No If so, how much? _____ For how long? _____

8. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? _____

9. How many pregnancies? _____ Births? _____ Breast Fed? ❒ Yes ❒ No How long? _____

10. When was your last physical exam? _____ By whom? _____

11. When was your last eye examination? _____ By whom? _____

12. When was your last mammogram?_____Where was it performed?_____

13. When and where was your last chest x-ray? _____ EKG? _____

14. Who is your personal physician, if any? _____Please list all physicians presently caring for you.

_____

15. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

16. Have you had any recent blood work done? ❒ Yes ❒ No Where? _____

17. Is there anything else you think the doctor should know? _____

_____

18. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

_____

_____

_____

HOSPITALIZATIONS (include where, when and why for each admission): _____

_____

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____