

WILLIAM A PORTUESE, M.D.

NAME			DATE
BIRTH DATE			GENDER: <input type="checkbox"/> M <input type="checkbox"/> F ARE YOU OR COULD YOU BE PREGNANT?
AGE:	HEIGHT:	WEIGHT:	# OF PAST PREGNANCIES
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			

PLEASE LIST PAST SURGERIES AND YEAR THEY TOOK PLACE

1 _____	4 _____
2 _____	5 _____
3 _____	6 _____

LIST ANY PREVIOUS COMPLICATION WITH SURGERY: \_\_\_\_\_

CURRENT MEDICAL PROBLEMS: \_\_\_\_\_

CURRENT MEDICATIONS, PLEASE LIST DOSE AND FREQUENCY: \_\_\_\_\_

KNOWN DRUG ALLERGIES: \_\_\_\_\_

ALCOHOL USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, AMOUNT: FREQUENCY:	TOBACCO USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, TYPE: AMOUNT:
COFFEE/CAFFEINE USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, AMOUNT: FREQUENCY:	DRUG USE <input type="checkbox"/> Y <input type="checkbox"/> N IF SO, TYPE: AMOUNT:

PARENTS HEALTH (IF DECEASED, INDICATE CAUSE OF DEATH):

SIBLINGS WITH SIGNIFICANT HEALTH PROBLEMS:

PLEASE CIRCLE ALL THAT APPLIES TO YOUR IMMEDIATE FAMILY (MOTHER, FATHER, SIBLINGS, GRANDPARENTS):

DIABETES	HIGH BLOOD PRESSURE	STROKE	BLEEDING DISORDERS	CANCER
ASTHMA	HEART PROBLEMS	EAR SURGERY	EARLY HEARING LOSS	HAYFEVER

I CERTIFY THAT THIS HISTORY FORM IS FILLED OUT COMPLETELY AND ACCURATELY.  
I HAVE ANSWERED ALL OF THE QUESTIONS TO THE BEST OF MY KNOWLEDGE

\_\_\_\_\_  
PATIENT SIGNATURE (PLEASE FILL OUT BACK OF PAGE) DATE