

# Valley Surgical Center of Minimally Invasive Surgery Medical History Form

Date: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Doctor \_\_\_\_\_

**FOR OFFICE USE ONLY:**

CC: \_\_\_\_\_

WT \_\_\_\_\_ HT \_\_\_\_\_ BMI \_\_\_\_\_ B/P \_\_\_\_\_ RESP \_\_\_\_\_ TEMP \_\_\_\_\_ PULSE \_\_\_\_\_

**MEDICAL HISTORY**

**ALLERGIES:** \_\_\_\_\_

Heart Disease .....yes \_\_\_ no \_\_\_  
 Angina  M.I  Coronary Bypass Surgery  Stroke  Abnormal Heart Beat

High blood pressure .....yes \_\_\_ no \_\_\_

High cholesterol .....yes \_\_\_ no \_\_\_

Diabetes .....yes \_\_\_ no \_\_\_

Asthma .....yes \_\_\_ no \_\_\_

Sleep Apnea .....yes \_\_\_ no \_\_\_

Snoring  Morning headache  Daytime drowsiness  BiPAP/CPAP

Reflux/ Heartburn/Esophagitis/Hiatal hernia .....yes \_\_\_ no \_\_\_

Venous stasis/ Poor circulation .....yes \_\_\_ no \_\_\_

Swollen legs  Ulceration

Arthritis of hips/knees/ankles/feet .....yes \_\_\_ no \_\_\_

Urinary Incontinence:

(leak of urine) with coughing/laughing/sneezing/straining .....yes \_\_\_ no \_\_\_

Deep Venous Thrombosis (blood clot in legs) .....yes \_\_\_ no \_\_\_

Blood thinning medication \_\_\_\_\_

Depression .....yes \_\_\_ no \_\_\_

Hernia .....yes \_\_\_ no \_\_\_

Have you ever received a blood transfusion? .....yes \_\_\_ no \_\_\_

Have you ever had hepatitis? .....yes \_\_\_ no \_\_\_

**MEDICATIONS:**

Please list all medications you currently use: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY:**

Please list any surgeries you have had in the past \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_