MEDICAL HISTORY (PAGE 2)

Abnomal bleeding?	Name:		Date:					
Mo		Middle Initial	Last					
Abnormal bleeding? Yes No Chest Pains? No Yes Explain: Asthma? Yes No No Sleep apnea? Yes No No No No No No No N	PERSONAL PAST ME	DICAL HISTORY: Hav	ve you ever had:					
Asthma?	HIV?	☐ Yes ☐ No						
Acid reflux?	Abnormal bleeding?	☐ Yes ☐ No	·					
Anemia? Yes No			• •					
Blood clots?		_	· · · · · · · · · · · · · · · · · · ·					
Painting spells? Yes			• — —					
Diabetes? Yes		_						
Kidney disease? Yes No MRSA? Yes No Papecmaker? Yes No No NRE? Yes NO Yes NRE? Yes Yes NRE? Yes Yes NRE? Yes NRE? Yes NRE? Yes NRE? Yes NRE	<u> </u>							
Pacemaker?			•					
Joint replacement?	•							
Latex allergy?								
Oxygen?	•							
Cancer?								
Other significant health issues? Do you need pre-operative antibiotics? PAST SURGERIES: Date: Type: Hospital: Surgeon: Have you had complications or bad reactions to anesthesia?								
Do you need pre-operative antibiotics? PAST SURGERIES: Date: Type: Hospital: Surgeon: Have you had complications or bad reactions to anesthesia? Yes No List: Have you ever had a transfusion? Yes No If so, when? Have you had a significant weight change in the last year? Yes No If so, indicate: gainlbs or losslbs Number of pregnancies? Number of children? Do you smoke? No Yes, how much: Do you smoke? No Yes, how much: Pakeve any of these illnesses occurred in your family? Check all that apply and indicate relationship to you: Illness Relationship to you diabetes Colon cancer diabetes Colon cancer breast cancer Type: Hospital: Surgeon: With the patient	Cancer?		Type of cancer.	·····				
PAST SURGERIES: Date: Type: Hospital: Surgeon: Have you had complications or bad reactions to anesthesia? Yes No List:	Other significant health is	sues?						
Date: Type: Hospital: Surgeon: Have you had complications or bad reactions to anesthesia? Yes No List: Have you ever had a transfusion? Yes No If so, when? Have you had a significant weight change in the last year? Yes No If so, indicate: gain Ibs or loss Ibs Number of pregnancies? Number of children? Do you smoke? No Yes, how much: Do you smoke? No Yes, how much: FAMILY HISTORY Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you: Illness Relationship to you high blood pressure Overland Overland diabetes Colon cancer theart disease Skin cancer breast cancer type of skin cancer other Other Greater's alignature) Relationship to patient Greater's alignature) (write self if you are the patient)		e antibiotics?						
Have you had complications or bad reactions to anesthesia? Yes No		Typo:	Hospital:	Surgoon:				
Have you ever had a transfusion? Yes No If so, when? Have you had a significant weight change in the last year? Yes No If so, indicate: gain Ibs or loss Ibs	Date.	iype.	1103pitai.	Surgeon.				
Have you ever had a transfusion? Yes No If so, when? Have you had a significant weight change in the last year? Yes No If so, indicate: gain lbs or loss lbs	•	ons or bad reactions to ane	sthesia? □Yes □No					
Have you had a significant weight change in the last year? Yes No If so, indicate: gainlbs or losslbs	List:							
Number of pregnancies? Number of children? Do you smoke?	Have you ever had a tran	sfusion?	□ No If so, when?					
Do you smoke? No Yes, how much: Do you drink alcohol? No Yes, how much: FAMILY HISTORY Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you: Illness Relationship to you ovarian cancer diabetes colon cancer heart disease skin cancer breast cancer type of skin cancer other other Form completed by Relationship to patient (write self if you are the patient)	Have you had a significar	nt weight change in the last	year? □Yes □No If so, indicate:	gainlbs or losslbs				
FAMILY HISTORY Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you: Illness Relationship to you Illness Relationship to you high blood pressure ovarian cancer diabetes colon cancer heart disease skin cancer breast cancer type of skin cancer other other Form completed by Relationship to patient (write self if you are the patient)	Number of pregnancies?	Number of children?	?					
Hilness high blood pressure diabetes colon cancer heart disease breast cancer other (patient's signature) Relationship to you ovarian cancer tolon cancer skin cancer type of skin cancer type of skin cancer (write self if you are the patient)	Do you smoke? ☐No FAMILY HISTORY	☐Yes, how much:	Do you drink alcohol?	☐Yes, how much:				
high blood pressure ovarian cancer diabetes colon cancer heart disease skin cancer breast cancer type of skin cancer other other Relationship to patient (write self if you are the patient)	•							
diabetes colon cancer heart disease skin cancer breast cancer type of skin cancer other other Form completed by Relationship to patient (write self if you are the patient)	Illness	Relationship to yo		Relationship to you				
heart disease skin cancer breast cancer type of skin cancer other other Form completed by Relationship to patient (write self if you are the patient)	high blood pressure		ovarian cancer					
breast cancer type of skin cancer other other Form completed by Relationship to patient (write self if you are the patient)	diabetes		colon cancer					
other other Form completed by Relationship to patient (write self if you are the patient)	heart disease		skin cancer					
Form completed by Relationship to patient (write self if you are the patient)	breast cancer		type of skin cancer					
(patient's signature) (write self if you are the patient)	other		other					
	Form completed by	(patient's signature)	Relationship to patient	(write self if you are the patient)				
	Nurse Signature	.	Physician Signature					

The SHAW Center / Lawrence W. Shaw, MD Medical History

Name:				Date:						
Birth date:				Heig	ht:	_	Weight:			
Parent(s) and/or Guard	lian(s):									
Referring Dr:				Fam	ily Dr.:					
Address:				Address:						
Reason for Visit:										
Have you seen another	doctor for this? Who									
Injury related? ☐ Yes	☐ No Job related?	☐Yes	□ No	Date of Injury	·	Symptom	s Onset:			
ALLERGIES	Latex Allergies?	□Yes	□ No	Blood Test to	Confirm?	□ Yes [□No			
	Environmental?	☐Yes	□ No	List:						
	Tape Allergies?	☐ Yes	□ No	List:						
	Drug Allergies?									
	Food Allergies?									
List all drug allergies ar	nd type of reaction:									
MEDICATIONS	(Attach list if more th	an ten pr	escription	n medications)						
Rx:				Rx:						
Rx:				Rx:						
Rx:										
Rx:				Rx:						
Rx:				Rx:						
Do you take insulin?	□Yes □No	Coumac	din, Plavi	x, etc.?	Yes □ No	Home Oxyg	jen? □Yes	□No		
(Daily) Aspirin? Yes	□No (Daily) lb	uprofen?	□Yes	□No Ste	roids? Yes	□No Vi	itamins? Yes	□No		
Other OTC Supplemen	ts? ☐ Yes ☐ No	List:								
Any metal implants/dev										
For any prescription the preferred pharmacy? _			-				address of your			