CRIGHTON OLIVE DUNN
SURGICAL GROUP INC.

Patient: ____________________________ Date: _____________ Social Sec. #:_________________
Date of Birth: ________________________ Height: _______ Weight: ______
Referring Physician: __________________ Ref Physician Phone: _____________

Have you seen us:	□ KY-3 TV	□ KOLR-10 TV	□ News-leader	□ 417 Magazine
(Check all that apply)	□ KY-3 Online	□ OnlineSearch	□ News-Leader Online	Other: ___________

What is your occupation? ____
What are you seeing the doctor for? ____
When did the problem first start or when did the injury occur? _________________

Have you ever had a reaction to penicillin? □ Yes □ No / **Any other drug?** ______________________

Are you allergic to Latex? □ Yes □ No

Allergies: ____ □ **I DO NOT HAVE KNOWN ALLERGIES**

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? □ **I DO NOT TAKE MEDICATIONS**
Please include both prescription and non-prescription medications.

Medication	Dose	#Times a Day
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________

Pharmacy – You Use or *Would Use*
____
____
____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? Check all that apply:

General

□ Tiredness	□ Fever	□ Lack of appetite	□ Night sweats
□ Weight loss	□ Weight gain	□ Chills	□ Difficulty sleeping

Eyes / Ears / Nose / Throat

□ Decreased Vision	□ Spots before your eyes	□ Hoarseness	□ Decreased hearing
□ Blurred/double vision	□ Ringing in ears		

Cardiovascular

□ Chest pain /tightness	□ Black-out episodes	□ Varicose veins	□ Shortness of breath (lying)
□ Heart racing	□ Irregular heart beat	□ Swelling of the legs	□ Discoloration hands / feet

Respiratory

□ Difficulty breathing	□ Coughing of phlegm	□ Coughing of blood	□ TB history
□ Sit up to breathe	□ Dry cough	□ Wheezing/asthma	

Gastrointestinal

□ Nausea	□ Vomiting	□ Red blood in stool	□ Change in bowel habits
□ Abdominal pain	□ Black stool	□ Vomiting of blood	□ Need for antacids

Urinary

□ Blood in urine	□ History of stones	□ Pain urinating	□ Freq urination (Night / Day)

Musculoskeletal

□ Muscle pain □ Lost muscle mass □ Muscle weakness □ Painful /Stiffness of joints

Skin

□ Rash □ Itching □ Easy bruising □ Skin ulcers

Neurological

□ Seizures □ Blindness □ TIA (mini-stroke) □ Dizziness
□ Tremors □ CVA (stroke) □ Difficulty w/thinking

Endocrine

□ Goiter □ Heat / Cold intolerance □ Change voice pitch □ Tremulousness of hands

Psychiatric

□ Depression □ Schizophrenia

Breast

□ Lumps □ Pain □ Discharge

TELL US ABOUT YOUR PAST MEDICAL HISTORY:

□ **NO MEDICAL PROBLEMS**

Neurological

□ Aneurysm
□ Neurological disease
□ Migraine
□ Concussion
□ Epilepsy
□ Stroke / TIA
□ Other: ___________

Endocrine

□ Diabetes
□ Thyroid disease
□ Other: ___________

Pulmonary

□ Pulmonary embolus
□ Emphysema
□ COPD
□ Asthma
□ Other:___________

Hepatic

□ Liver disease

Infectious

□ HIV/AIDS
□ Hepatitis A/B/C
□ Tuberculosis
□ Other: ___________

Gastrointestinal

□ Reflux / GERD
□ Stomach ulcer
□ Other: ___________

Renal

□ Kidney disease
□ Kidney stones
□ Other: ___________

Cancer

□ Cancer, specify type:
____
____

□ Anesthesia Complications

Cardiovascular

□ Coronary artery disease
□ Past heart attack
□ Past Heart Surgery
□ Heart murmur
□ High cholesterol
□ DVT / Blood clot
□ Defibrillator implanted
□ High blood pressure
□ Pacemaker implanted
□ Peripheral vasc disease
□ Arrhythmia / Irregular Heart Beat
□ Heart valve dysfunction

TELL US ABOUT YOUR PAST SURGICAL HISTORY:

□ **NO PREVIOUS SURGICAL HISTORY**

Type of Surgery	Date	Performing Surgeon

Do you now, or have you ever used tobacco? □ Yes (yrs____) □ No □ Quit (yr______) Type __________
Do you now, or have you ever used Alcohol? □ Yes □ No □ Quit (yr______)
Do you now, or have you ever used recreational drugs? □ Yes □ No □ Quit (yr______)

TELL US ABOUT YOUR PAST FAMILY HISTORY:

□ **NEGATIVE FAMILY HISTORY**

Has any blood relative had the following:

□ Heart problems/ disease □ Stroke / TIA □ Diabetes □ Cardiac arrest / Sudden death
□ High blood pressure □ Kidney disease □ High cholesterol □ Deep Vein Thrombosis (DVT)
□ Myocardial Infarction □ Anesthesia Complication
□ Cancer:

Family Relation	Type of Cancer	Age Diagnosed

ADDITIONAL SURGICAL SCREENING QUESTIONS (NEEDED PER HOSPITAL REQUIREMENTS):

□ Yes □ No Are you age 60 or older?
□ Yes □ No Are you on oxygen at any time? (even just at night or as needed)
□ Yes □ No Do you take Insulin?
□ Yes □ No Have you had any problems with your heart? (Such as coronary artery disease, heart attack, blockages, stents, heart failure, irregular rhythms, Atrial Fib, murmurs, congenital heart defects, history of heart surgery, etc..)
□ Yes □ No Do you have a pacemaker and/or defibrillator? (ICD or AICD)
□ Yes □ No Have you ever had a stroke or mini-stroke (TIA)?
□ Yes □ No Do you have peripheral vascular disease (PVD) or poor circulation in your legs?
□ Yes □ No Have you been told you have sleep apnea?
□ Yes □ No Are you pregnant?
□ Yes □ No Do you have a *personal or family* history of malignant hyperthermia?
□ Yes □ No Have you ever had a serious complication with anesthesia?
□ Yes □ No Have you been told you have a difficult airway?
□ Yes □ No Have you been told by a dentist that you have a small mouth?
□ Yes □ No Do you have myasthenia gravis?
□ Yes □ No Do you have kidney disease that requires dialysis?
□ Yes □ No Do you have liver disease? (End stage liver disease, cirrhosis)
□ Yes □ No Do you have a bleeding disorder?
□ Yes □ No Do you take medication for high blood pressure and/or Digoxin (Lanoxin)?
□ Yes □ No Are you a diabetic or do you take antidiabetic medications?
□ Yes □ No Do you take diuretics (water pills)?
□ Yes □ No Do you take anti-coagulants? (blood thinners, platelet inhibitors, etc.) If you normally take these and have stopped for your procedure, choose "yes".
□ Yes □ No Have you had surgery within the last month, if "yes" what type? ________________

(Complete the following section ONLY if patient being seen is a "female" patient)

Have you ever had breast tumors, cysts or other disease? □ Yes □ No
Have you ever been pregnant? □ Yes □ No (Number____)
Have you had a hysterectomy? □ Yes □ No
Have you had any other surgery on your female organs? □ Yes □ No
Are you currently taking hormones or birth control pills? □ Yes □ No
If still menstruating; date of your last menstrual period? __________ □ N/A

(Complete the following section ONLY if the patient being seen is a" child")

□ Yes □ No Is child **less** than 3 years old **AND** scheduled for a tonsillectomy?
□ Yes □ No Does child have any congenital abnormalities or syndromes?

Complete the following section if being seen for “Vein & Vascular Symptoms”. **ALL PATIENT PLEASE SIGN BELOW!**

LEFT LEG: Feeling of Heaviness	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
LEFT LEG: Feeling of Achiness	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
LEFT LEG: Swelling Symptoms	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
LEFT LEG: Throbbing Sensation	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
LEFT LEG: Feeling of Itchiness	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
What effect have your varicose veins had - on the appearance of your leg this past week?	Not at all noticeable	Slightly noticeable	Moderately noticeable	Very noticeable	Extremely noticeable	
What effect have your varicose veins had on your ability to work or perform your usual daily activities this past week?	No Effect	Full work and activity but have symptoms	Mildly reduced work and daily activity	Moderately reduced work and daily activity	Severely reduced work and daily activity	Unable to work or do normal daily activity

RIGHT LEG: Feeling of Heaviness	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
RIGHT LEG: Feeling of Achiness	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
RIGHT LEG: Swelling Symptoms	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
RIGHT LEG: Throbbing Sensation	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
RIGHT LEG: Feeling of Itchiness	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
What effect have your varicose veins had - on the appearance of your leg this past week?	Not at all noticeable	Slightly noticeable	Moderately noticeable	Very noticeable	Extremely noticeable	
What effect have your varicose veins had on your ability to work or perform your usual daily activities this past week?	No Effect	Full work and activity but have symptoms	Mildly reduced work and daily activity	Moderately reduced work and daily activity	Severely reduced work and daily activity	Unable to work or do normal daily activity

Patient or Guardian Statement & Signature: Everything I have answered is true and correct to the best of my knowledge.

______________________________ Patient or Guardian Signature

______________________________ Date

SIGN HERE!