CRIGHTON OLIVE DUNN
SURGICAL GROUP INC.

Patient: _____ Date: _____ Social Sec. #:_____
Date of Birth: _____ Height: _____ Weight: _____
Referring Physician: _____ Primary Care Physician: _____
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? _____
What is your marital status? _____
When was your last colonoscopy? (Month/Year) _____
When was your last mammogram? (Month/Year) _____
When was your last flu shot? (Month/Year) _____

Do you have any Drug Allergies? □ Yes □ No / _____

Are you allergic to Latex? □ Yes □ No

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*

Please check only symptoms that apply to current visit:

Breast
□ Lumps □ Pain □ Discharge

General
□ Weight gain □ Chronic Fatigue □ Chills □ Night sweats
□ Weight loss □ Fever □ Difficulty Sleeping

Eyes / Ears / Nose / Throat
□ Decreased Vision □ Runny Nose □ Hoarseness □ Decreased hearing
□ Blurred/double vision □ Bloody Nose □ Sore Throat □ Ringing in Ears

Respiratory

□ Difficulty breathing □ Cough □ Wheezing/asthma
□ Shortness of breath at night □ Coughing of blood □ TB history

Cardiovascular

□ Irregular Heart Beat □ Black-out episodes
□ Feeling light headed □ Edema/swelling

Gastrointestinal

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

Urinary

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

Musculoskeletal

□ Muscle pain □ New joint pain □ Muscle weakness/loss of mass

Skin

□ Rash □ Itching □ Easy bruising

Neurological

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

Endocrine

□ Goiter □ Diabetes □ Heat and cold intolerance

Psychiatric

□ Anxiety □Depression □ Schizophrenia

TELL US ABOUT YOUR PAST MEDICAL HISTORY: □ NO MEDICAL PROBLEMS

(Check all that apply)

□ Asthma □ Diabetes □ Hepatitis □ Thyroid Disease
□ Arthritis □ Defibrillator/pacemaker □ Liver Disease □ Varicose Veins
□ Anemia □ Hypertension (High blood pressure) □ Migraines □ Spider Veins
□ Cancer □ Heart disease □ PVD
□ Concussion □ Hyperlipidemia (High cholesterol) □ Reflux (GERD)
□ COPD □ Kidney Disease □ Stroke

TELL US ABOUT YOUR PAST SURGICAL HISTORY: □ NO PREVIOUS SURGICAL HISTORY

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

	Family Member		Type	Family Member	Age Diagnosed
□ Heart Problems	_____	□ Cancer			
□ High Blood Pressure	_____		_____	_____	_____
□ Diabetes	_____		_____	_____	_____
□ Cardiac arrest	_____		_____	_____	_____
□ DVT (Deep Vein Thrombosis)	_____		_____	_____	_____

□ High Cholesterol _____ _____ _____ _____
□ Kidney Disease _____
□ Stroke/TIA _____

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 <u>any</u> 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 PATIENTS 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