SHELDON R. COBER, M.D.
AUSTIN G. HAYES, M.D.

MEDICAL HISTORY

PATIENT NAME: DATE:
HEIGHT ________________ WEIGHT _______________ BRA SIZE (If for breast surgery)
TOBACCO USE: None ________ Smoke ___________ Chew _______ ASPIRIN USE: None ________ Occasional _____ Frequent
ALCOHOL USE: None ________ Type ____________________ Frequency

CHECK IF YOU HAVE HISTORY OF: Email Address:

NO		YES	DETAILS / DATES
	Bleeding Disorders/Problems		
	Diabetes		
	Cancer		
	Heart Disease Lung		
	Disease		
	Ulcers Liver		
	disease Bowel		
	Disease		
	Kidney Disease		
	Epilepsy or Neurological Disorder		
	Hepatitis		
	High Blood Pressure		
	MRSA Infection		

CHECK IF YOU HAVE FAMILY HISTORY OF:

NO		YES	FAMILY MEMBER	MATERNAL OR PATERNAL
	Cancer			
	Diabetes			
	High Blood Pressure			
	Heart Disease Bleeding			
	Disorders/Problems			

LIST DRUG ALLERGIES:	SIDE EFFECTS	LIST MEDICATIONS / DOSAGE
1.		1.
2.		2.
3.		3.
4.		4.

ANY COMPLICATION OF ANESTHESIA? YES ____________ NO
IF YES: Local ___________General ___________Explain

PREVIOUS SURGERY	DATE	EXPLAIN

Pharmacy of Choice:
(include location)