WILLIAM A PORTUESE, M.D.

NAME			DATE
BIRTH DATE		GENDER: ☐M ☐F	ARE YOU OR COULD YOU BE PREGNANT?
AGE:	HEIGHT:	WEIGHT:	# OF PAST PREGNANCIES
MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED			

PLEASE LIST PAST SURGERIES AND YEAR THEY TOOK PLACE

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

LIST ANY PREVIOUS COMPLICATION WITH SURGERY: _____

CURRENT MEDICAL PROBLEMS: _____

CURRENT MEDICATIONS, PLEASE LIST DOSE AND FREQUENCY: _____

KNOWN DRUG ALLERGIES: _____

ALCOHOL USE ☐Y ☐N *IF SO,* AMOUNT: FREQUENCY:	TOBACCO USE ☐Y ☐N *IF SO,* TYPE: AMOUNT:
COFFEE/CAFFEINE USE ☐Y ☐N *IF SO,* AMOUNT: FREQUENCY:	DRUG USE ☐Y ☐N *IF SO,* TYPE: AMOUNT:

PARENTS HEALTH (IF DECEASED, INDICATE CAUSE OF DEALTH):

SIBLINGS WITH SIGNIFICANT HEALTH PROBLEMS:

PLEASE CIRCLE ALL THAT APPLIES TO YOUR IMMEDIATE FAMILY (MOTHER, FATHER, SIBLINGS, GRANDPARENTS):

DIABETES	HIGH BLOOD PRESSURE	STROKE	BLEEDING DISORDERS	CANCER
ASTHMA	HEART PROBLEMS	EAR SURGERY	EARLY HEARING LOSS	HAYFEVER

I CERTIFY THAT THIS HISTORY FORM IS FILLED OUT COMPLETELY AND ACCURATELY.
I HAVE ANSWERED ALL OF THE QUESTIONS TO THE BEST OF MY KNOWLEDGE

_____ _____

PATIENT SIGNATURE DATE

(PLEASE FILL OUT BACK OF PAGE)

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