ECHELON
SURGICAL SPECIALISTS

I attest that the information contained in this form is a complete and accurate reflection of my current health status and medical history.

Signature Date

Name _____
Last First Middle

Address _____

City _____ **State** _____ **Zip** _____

Phone number _____ **May we text this phone number?** _____

Email _____ **May we email this address?** _____

Age _____ **Birthdate** _____ **Social Security # (last 4 digits)** _____

Female _____ **Male** _____ **Marital Status** _____ **Employer/Occupation** _____

Reason for Visit _____

Referred By _____

Family Physician _____

Emergency Contact (relationship & phone number) _____

Preferred Pharmacy Name and Location _____

Current Medications (Dose and Frequency - continue on back as necessary)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you take vitamins, herbal supplements, or diet pills? _____

Do you take aspirin, NSAIDS, MOA inhibitors or blood thinners? _____

Are you COVID-19 vaccinated? ☐ Yes ☐ No **Are you boosted?** ☐ Yes ☐ No **Positive Test Date(s)** _____

Do you have any of the following medical conditions?
☐ Latex Allergy ☐ Sleep Apnea ☐ Diabetic ☐ Insulin Pump ☐ Pacemaker ☐ Defibrillator ☐ Home Oxygen
☐ Anticoagulants ☐ MRSA ☐ VRE ☐ C-Diff ☐ HIV ☐ Hepatitis C ☐ None of these

Allergies ☐ No ☐ Yes (please list all) _____

Height _____ **Weight** _____

Social History
Tobacco/ Nicotine ☐ No ☐ Yes How much? _____ Former _____ Quit: _____
Alcohol ☐ No ☐ Yes Number of drinks _____ per _____
Drug Use ☐ No ☐ Yes Type/frequency: _____

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Medical History (Please check ALL that apply with details below)

☐ Breast Cancer ☐ Breast Lumps ☐ Breast Pain ☐ Breast Asymmetry ☐ Nipple Discharge ☐ Other Breast _____ ☐ None of the above	☐ Blood Clots ☐ Anemia ☐ Clotting Disorder ☐ Bruising (easily) ☐ Transfusions ☐ Enlarged Lymph Nodes ☐ Other Endrocrine/Lymphatic _____ ☐ None of the above	☐ Heart Murmur ☐ Heart Failure ☐ Pacemaker/Defibrillator ☐ Heart Attack ☐ Stroke ☐ Atrial Fibrillation ☐ Other Cardiovascular _____ ☐ None of the above
☐ Skin Cancer ☐ Melanoma ☐ Changing Lesion ☐ Other Dermatologic _____ ☐ None of the above	☐ Pulmonary Embolism/DVT ☐ Shortness of Breath ☐ Bronchitis ☐ Asthma ☐ Chronic Cough ☐ Other Respiratory _____ ☐ None of the above	☐ Depression ☐ Anxiety Disorder ☐ Schizophrenia ☐ Bipolar Disorder ☐ Other Psychiatric _____ ☐ None of the above

Medical History Additional Information (diagnoses, dates, treatments)

_____

_____

_____

Previous Surgical History (Procedure/Surgeon/Date)

_____

_____

Family Medical History (including cancer, heart history, blood clots/pulmonary embolism)

_____

Female Patients

Date of Last Mammogram_____Location_____Result_____

Method of birth control_____Number of Births_____Number of Pregnancies_____

Could you be pregnant now?_____Are you attempting pregnancy?_____

OFFICE USE ONLY ○ PCP PREOP ○ ANESTHESIA PREOP ○ _____