1. Do you have any medical problems?  
Please list all medical problems in the space below.

2. Do you take any medications?  
Please list all medications, vitamins and herbal supplements in the space below.

3. Do you take aspirin, Coumadin, Plavix or any other blood thinning medications?  ___ YES  ___ No  
If yes, which blood thinning medication do you take?

4. Have you ever had any surgery before?  
Please list all previous surgeries and the approximate dates in the space below.

5. Do you have any allergies to any medications?  
Please list all medication allergies AND the type of reaction to each medication in the space below.

6. Do you have any medical problems in your family. Please list any medical problems in your immediate family (mother, father, sister, brother, son or daughter only) below.

7. Do you smoke cigarettes or use any other nicotine containing products?  
YES ___ No ___ If yes, which product? _______ how many per day? _______ and for how many years? _______  
If you quit, how long ago? _______  
Do you drink alcohol?  
YES ___ No ___ If yes, how often? ____________________________  
Do you use any other recreational drugs? Please answer this honestly as certain recreational drugs are extremely dangerous when combined with general anesthesia.  
YES ___ No ___ If yes, which drug and how often? ____________________________
8. Is there anything else bothering you today? Please include all body systems including but not limited to nausea, vomiting, diarrhea, shortness of breath, headaches, fevers, chills and chest pain.

9. What is your **height**? ___________  What is your **weight**? ________________

10. Have you ever had an eating disorder or have you ever taken diet or weight reduction pills?
YES ___  No ___

11. Are there any other medical problems you have that are not addressed by this form?
YES ___  No ___

12. Is there anything you would like to discuss with Dr. Morin today privately?
YES ___  No ___

13. **Female** questions
   - Are you pregnant or breast feeding? YES ___  No ___
   - Are you taking birth control pills? YES ___  No ___
   - Are you planning to become pregnant in the future? YES ___  No ___
   - Are you planning to breast feed in the future? YES ___  No ___  __________________
   - What was the date of your last mammogram (if applicable)?
   - How many times have you been pregnant? __________________
   - How many times have you given birth? __________________

14. **Signature**
I have provided a complete and accurate overview of my current medical problems and my past medical history to the best of my knowledge. I understand that this information is important in guiding my medical and surgical care and I understand that omissions and inaccuracies can increase my risk of medical and surgical complications.

Signature

Printed Name

Date