Abington Jefferson Health

Date: _____

Name: _____ **DOB:** _____

Height: _____ **Approximate weight:** _____

Referred By: _____

Primary Care Physician:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Pharmacy:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Please Check Preferred Surgeon:

___ Dr. Fernando Bonanni ___ Dr. Gintaras Antanavicius ___ Dr. Kristin Noonan

Medications	Dosage	Frequency

Allergies to Medications or Foods	Reaction

Name:_____ DOB:_____

DO HAVE OR HAVE YOU EVER HAD:

	Yes	No	Reaction
Latex allergy			
Blood transfusion			
Reaction to anesthesia			
Exposure to tuberculosis			
Exposure to hepatitis			
Exposure to HIV			

SOCIAL HISTORY:

Do you use Tobacco? Y_____ N_____ # years_____ Pack(s) per day_____

Have you used tobacco in the past? Y_____ N_____ How Long Since Quitting_____

Do you drink alcohol? Y_____ N_____ Frequency_____

Drug abuse history: Y_____ N_____ Explain_____

Occupation: _____

Anyone living at home with you to help after surgery?_____

PAST MEDICAL HISTORY:

	Yes	No	Describe	Year diagnosed
Heart Disease				
Lung Disease				
Intestinal Disease				
Liver Disease				
Vascular Disease				
High Blood Pressure				
Diabetes				
Sleep Apnea				
Cancer				
Blood Disorder				

Name:_____ DOB:_____

PAST SURGICAL HISTORY / HOSPITALIZATIONS

Type of Surgery / Hospitalization	Year	Facility / Hospital

FAMILY HISTORY: Have your parents, grandparents or siblings ever had?

	Description	Relationship Please list (Mother / Father / Sibling Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather)
Heart Disease		
Lung Disease		
Intestinal Disease		
Liver Disease		
Vascular Disease		
High Blood Pressure		
Diabetes		
Sleep Apnea		
Cancer		
Blood Disorder		
Obesity		

Any other pertinent medical history for yourself or your family?_____
_____
_____
_____

Name:_____ **DOB:**_____

PSYCHIATRIC HISTORY:

Have you ever seen a psychologist, psychiatrist or therapist in the past? Y_____ N_____

Have you ever been hospitalized for a psychological issue? Y_____ N_____

Psychologist/Psychiatrist Information:

Name: _____

Address:_____

_____

Phone: _____

Fax: _____

Currently seeing? Y_____ N_____

Therapist/Counselor Information:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Currently seeing? Y_____ N_____

-Please fill out completely for all physicians who have participated in your care-

Cardiologist:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Endocrinologist:

Name: _____

Address:_____

_____

Phone: _____

Fax: _____

Gastroenterologist:

Name: _____

Address:_____

_____

Phone: _____

Fax: _____

Hematologist:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

OB/GYN:

Name: _____

Address:_____

_____

Phone: _____

Fax: _____

Orthopedist:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Pulmonologist:

Name: _____

Address:_____

_____

Phone: _____

Fax: _____

Other Specialty:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____