

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Surgery:**

Lung  \_\_\_\_\_

Vascular  \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Habits: (per day)**

Sleep (how much) \_\_\_\_\_ Do you sleep well? \_\_\_\_\_

Tobacco (how much) \_\_\_\_\_ How Long? \_\_\_\_\_

Alcohol (how much) \_\_\_\_\_ Coffee/tea (how much) \_\_\_\_\_

Other: \_\_\_\_\_

Special Diet? \_\_\_\_\_ What kind? \_\_\_\_\_

**OB-Gyn:**

No. of pregnancies \_\_\_\_\_

Miscarriages \_\_\_\_\_

Living births \_\_\_\_\_

Premature births \_\_\_\_\_

Did any child weigh over 9lbs: \_\_\_\_\_

**Family History:**

Father: Living \_\_\_\_\_ Age \_\_\_\_\_

Deceased \_\_\_\_\_ Age \_\_\_\_\_

Cause of Death \_\_\_\_\_

If living, state of health \_\_\_\_\_

Mother: Living \_\_\_\_\_ Age \_\_\_\_\_

Deceased \_\_\_\_\_ Age \_\_\_\_\_

Cause of Death \_\_\_\_\_

If living state of health \_\_\_\_\_

**Brothers and Sisters:**

Name

Living

Deceased

Any medical Problems or Cause of death

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Children:**

Name

Living

Deceased

Any medical Problems or cause of death

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other Information that your surgeon should know:**

\_\_\_\_\_

\_\_\_\_\_