Darrel Pierce MD

Patient History

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last name: First name: Age: Sex: M F

Presenting problem or proposed surgery:

ILLNESS/INJURY: Please check if you have ever had any of the following

Yes	No		Yes	No	
		High blood pressure			Kidney stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart attack			Thyroid problem
		Chest pain/tightness			Lung problems/asthma
		History of heart murmur			Shortness of breath
		Stroke			Accidents/broken bones (list)
		Cancer			
		Hepatitis			
		Yellow jaundice			
		Gallstones			

OPERATIONS: List names and dates of all operations you have had

Year	Name of operation	Type of anesthetic, if known	Complications

List any hospital admissions or medical conditions not listed above

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_____

DRUGS: Please list all drugs you take and their dosages

Drug	Dosage	Drug	Dosage

ALLERGIES: Please list type and reaction

Drug	Reaction	Drug	Reaction

With God all things are possible Matthew 19:26