FRANK JOHNSON JR., M.D. 13400 N. MERIDIAN ST., SUITE 600 CARMEL, IN 46032

MEDICAL INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH**_____ **HEIGHT**_____ **WEIGHT**_____

PAST MEDICAL HISTORY **(Please circle any that apply to your health)**

Asthma Chronic Bronchitis Depression Emphysema GI Ulcers Hypertension Metal Implant Rheumatoid Arthritis Thyroid Disorder

Anemia Cirrhosis Diabetes Fibromyalgia Glaucoma Heart Disease Osteoporosis Stroke Pacemaker Stents

Blood Clots/DVT COPD Congestive Heart Failure Hepatitis HIV Positive Renal Failure Seizure Sickle Cell Anemia

List any other Medical History:_____

PAST SURGICAL HISTORY

PROCEDURE	DATE	PROCEDURE	DATE	PROCEDURE	DATE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATIONS **(Please list all prescription and non-prescription medications, you can attached a list if more room is needed)**

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PLEASE LIST ANY DRUG ALLERGIES or INDICATE IF "NONE" _____

Are you allergic to: (please circle) Latex Contrast Dye Adhesives Seafood

Have you or anyone in your family had an unusual reaction to anesthesia? _____

FAMILY HISTORY **(please circle if anyone in your family has had any of the following)**

Alcoholism Asthma Bleeds Easily Diabetes Glaucoma Hypertension High Cholesterol

Anemia Arthritis Cancer Epilepsy Heart Disease Migraine Stroke Thyroid Disorder

SOCIAL HISTORY

Do you smoke? Yes or No If yes, pack per day_____ Number of Years_____ Past History of Smoking? Yes or No

Alcohol Use? Do you average 3 or more alcoholic beverages per day? Yes or No Do you use Recreational Drugs? Yes or No

MEDICAL REVIEW OF SYSTEMS **(Please circle any of the following that are applicable to your *current* health)**

GENERAL HEALTH:
Weight Gain/Loss
Fatigue
Fever

EYES:
Vision Changes
Dryness of Eyes
Itching of Eyes

CARDIOVASCULAR
Chest Pain
Palpations
Change in Heart Rate
Leg Swelling

ENT:
Hearing Loss
Nasal Discharge
Sore Throat
Nosebleeds

RESPIRATORY:
Shortness of Breath
Cough
Wheezing
Snoring

GASTROINTESTINAL:
Abdominal Pain
Nausea
Vomiting
Bloody Stools
Constipation

GENITOURINARY:
Dysuria
Incontinence
Urinary Tract Infection

SKIN:
Skin Lesions
Skin Wound
Skin Infection

NEUROLOGIC:
Confusion
Convulsions
Dizziness
Fainting
Weakness

MUSCULOSKELETAL:
Back Pain
Neck Pain
Joint Pain

ALLERGIC-IMMUNOLOGIC:
Hives
Rashes

PSYCHIATRIC:
Suicidal Thoughts
Suicidal Attempts
Insomnia
Depression

HEME-LYMPH:
Easy Bruising
History of Blood Clots

****IF NONE OF THE ABOVE APPLY TO YOUR CURRENT HEALTH, PLEASE CHECK HERE** ☐

THE ABOVE INFORMATION IS COMPLETE AND ACCURATE_____ **DATE:**_____