Mark D. Widmann, MD, FACS
Federico A. Steiner, MD
Warren D. Widmann, MD, FACS
Lynne R. Tamburrino, RN, APN-C

ROOM: _____ **Patient Name:** ________________________ **Age:** __________ **Date:** ________________________
MDW **FAS**
Referring Physician: ___________________ **Primary Physician:** ____________________________________

CC: What is the main reason for your visit today? (Describe in detail) ________________________

____

____

History of Present Illness (physician use) ____

____

____

List any Personal past illnesses, active medical problems and previous surgery with dates:

Do you smoke? Yes No Did you ever smoke? Yes No For how many years?______
How many packs/day?________ When did you quit?______

Do you exercise regularly? Yes No If so, what is your routine?____________________

Please list all current medications, including aspirin and vitamins dose and schedule:

Medication	Dose	Route	Frequency

Please list all ALLERGIES or DIETARY RESTRICTIONS:

Allergen/Drug/Dietary Item	Reaction

________________________ (Patient) ___________________________ (Physician)

(Signature) (Signature)

For office use only

Weight:	BP:
02 sat: Temp:	Pulse:

Morristown Office: 100 Madison Ave., Suite 4101, Carol G. Simon Cancer Center, Morristown Memorial Hospital, Morristown, NJ 07960
Mailing Address: P.O. Box 1348, Morristown, NJ 07962 • **Phone:** 973-644-4844 **Fax:** 973-644-4776

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PATIENT QUESTIONNAIRE

1) Have you taken aspirin in the last week? ………Yes No
If yes, how much & how often?________

2. Do you have any bleeding tendencies or problems with clots in the legs or lungs?…Yes No

3. Have you taken any cortison or steroids in the past 6 months…………………………… Yes No

4. Do you have a cold?…………………………… Yes No

5. Do you have a cough?………………………… Yes No

6. Have you ever had a problem with anesthesia? Yes No

7. Has anyone in your family ever had a problem with anesthesia?………………………… Yes No

8. Do you have asthma?………………………….. Yes No

9. Have you had any difficulties with breathing?... Yes No

10. Did you ever smoke?………………………….. Yes No

11. Do you have a heart murmur or artificial joint?…………………………… Yes No

12. Have you ever had a heart attack or or irregular heart beat?…………………….Yes No

13. Have you ever had angina or pain in the chest?.. Yes No

14. Could you be pregnant?……………………….. Yes No

15. Do you have any thyroid problems?………….. Yes No

16. Do you have more than 2 alchoholic drinks beer/wine etc.- per day?…………….……… Yes No

17. Have you ever been jaundiced (yellow)?…….. Yes No

18. Have you ever had hepatitis?………………… Yes No

19. Do you have heartburn, hiatal hernia or ulcers? Yes No

20. Do you have diabetes?………………………. Yes No

21. Do you have kidney disease?…………………. Yes No

22. Are you under treatment for high blood pressure? Yes No

23. Have you ever had a stroke,mini-stroke or TIA? Yes No

24. Have you ever had epilepsy, seizures or fainting spells?……………………………………… Yes No

25. Do you have an arm or leg that becomes numb or weak?…………………………………… Yes No

26. Do you have any limited motion?……………… Yes No

27. Do you have any chipped or loose teeth, dentures, caps or braces?…………………… Yes No

ADDITIONAL SPACE FOR YES ANSWERS: ____

____

____

____

________________________ (Patient) ____________________________ (Physician)

(Signature) (Signature)

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