JATINDER S. SEKHON, M.D

SUSAN H. BARTON, M.D

NAME: ____________________

Medical History: ____________________

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Medication/Dosage: ____________________

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Allergies: ____________________

(MEDICAL) **Family History:** (Please include family member) ____________________

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Surgical History: (Any abdominal or pelvic surgeries) ____________________

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Caffein Intake:

Coffee: If so quantity and frequency? ____________________

Tea: If so quantity and frequency? ____________________

TOBACCO: YES NO If so, how many a day? ____________________

ALCOHOL: YES NO If so quantity and frequency? ____________________

COVID VACCINE: YES NO If so brand and last dose date: ____________________

WEIGHT: __________ **HEIGHT:** __________

ANY SLEEP APNEA: YES NO