Piedmont Stone Center, PLLC

MOBILE LITHOTRIPSY

MEDICAL HISTORY FOR EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Height: _____ Weight: _____ Primary Dr: _____

Pregnant ☐ **No** ☐ **Yes**

Post Menopausal for 1 year ☐ **No** ☐ **Yes**

Tubal Ligation ☐ **No** ☐ **Yes**

Hysterectomy ☐ **No** ☐ **Yes**

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Heart Problems:	**Yes**	**No**	**When**
Chest pain/Angina?	☐	☐	_____
Heart attack?	☐	☐	_____
Congestive heart failure?	☐	☐	_____
Irregular heart beat?	☐	☐	_____
Rheumatic heart disease?	☐	☐	_____
Pacemaker?	☐	☐	_____
Defibrillator?	☐	☐	_____
Heart surgery or procedure?	☐	☐	_____
Date of last EKG/Facility			_____

	Yes	**No**
High blood pressure?	☐	☐
Stroke?	☐	☐
Diabetes?	☐	☐
Hepatitis?	☐	☐
Joint or muscle problems?	☐	☐
Ulcer disease?	☐	☐
Hiatal hernia?	☐	☐
Seizures?	☐	☐
HIV?	☐	☐
Autoimmune Disease?	☐	☐
Blood clotting disorder?	☐	☐
Cancer ?	☐	☐
Kidney Stones?	☐	☐

Lung Problems:

Asthma/wheezing?	☐	☐
Pneumonia?	☐	☐
Emphysema?	☐	☐
Sleep apnea?	☐	☐

Please bring C-Pap / breathing machine for your lithotripsy

Other Medical Conditions:

_____

_____

List all previous surgical procedures including dates: ☐ **No Surgical Procedures**

_____ _____

_____ _____

_____ _____

_____ _____

Did you have problems with anesthesia or surgery? ☐ Yes ☐ No If yes, explain: _____

List all allergies to foods, medications, and/or latex: ☐ **No Known Allergies**

Name	*Reaction*	*Name*	*Reaction*

List all medications; prescriptions, herbals, or over-the-counter drugs below:

Name	*Dose*	*How often*	*Name*	*Dose*	*How often*

Diabetes Medications: If yes, List: _____

Do you take any weight loss medications? ☐ Yes ☐ No If yes, list: _____ Last dose _____

Any "blood-thinning" medications? ☐ Yes ☐ No If yes, list: _____ Last dose _____

Last dose of any Aspirin products _____ Last dose of any Non-Steroidal products _____

Are you in a pain management clinic or a substance abuse program? ☐ Yes ☐ No Where? _____

Physician/Counselor: _____ Phone _____ Medication _____

Do you: ☐ Smoke ☐ Dip, chew, or snuff ☐ Vape or E-cigarettes ☐ Take CBD oil ☐ Drink alcohol; frequency? _____

☐ Recreational drugs; list _____ Last date of use _____

Patient Signature _____ **Date** _____ **Time** _____

Clinical Staff Signature _____ **Date** _____ **Time** _____