

**Fleming County Hospital**  
**Larien D. Kearns, MD**  
**General Surgeon**  
**732 Elizaville Road - P.O. Box 388**  
**Flemingsburg, Kentucky 41041-0388**  
**(606) 849-2675 fax (606) 849-2743**

\_\_\_\_\_  
Patient Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**PERTINENT MEDICAL HISTORY**

Check All Apply To You:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Bleeding Disorders      | <input type="checkbox"/> Cancer (list type) _____  |   |
| <input type="checkbox"/> Deep Vein Thrombosis    | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Diverticulitis       |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Excessive Scarring   |
| <input type="checkbox"/> Gout                    | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Heart Valve Problems |
| <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> HIV                     | <input type="checkbox"/> Kidney or Liver Disease   | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Post Op Nausea/Vomiting | <input type="checkbox"/> Prior Neck/Head Radiation | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Seizures                | <input type="checkbox"/> Stomach Ulcers            | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Other History             |   |

**DO ANY FAMILY MEMBERS HAVE?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Bleeding Disorders  |
| <input type="checkbox"/> Cancer _____     | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Excessive Scarring  |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney or Liver Disease | <input type="checkbox"/> Other _____         |

Prior Surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Current Medications: (If you have a list, we can copy it) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List All Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Pharmacy Address/Phone Number