Patient name________________________________ Birth Date_____________________

Medical History

Please list all your past and present medical problems. Include non-surgical hospitalizations.

- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________

Surgical History

Please list all past surgeries. Don't forget tonsils, gall bladder, appendix, hernia surgeries, hysterectomies, c-sections, plates and pins.

- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________
- ___________________________________

Social History

Do you or did you smoke cigarettes? ○ Yes ○ No

If yes, for how many years and how many packs per day? ____

If you quit, when did you quit? _____________________________

Do you drink alcohol? ○ Yes ○ No

If yes, what do you drink, and how many drinks will you have in a week or a month?

____

Any history of illegal drug use? ○ Yes ○ No

If yes, please elaborate. ____

Patient name________________________________ Birth Date_____________________

Medications

Please list all medicines and treatment that you take or use. Don't forget over-the-counter medicines, inhalers, C-PAP and oxygen.

- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________

Family History

Please list all relevant or significant illness in your close blood relatives.

- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________
- ____________________________________ • ____________________________________

Allergies (medications, foods, other significant allergies)

____

____