Surgical Associates, S.C.
Patient Medical History Form

Patient's Name_____DOB _____

Reason for Appointment_____Today's Date_____

Past Medical History: (Circle all that apply to you) **Check here if none _____**

Asthma Bleeding Disorder Bronchitis Chest Pain Depression Diabetes COPD Foot/Leg Ulcers

Heart Attack Heart Disease Heart Murmur Heart Valve Problems High Blood Pressure Irregular Heartbeat

Jaundice Kidney Disease Stroke Thyroid Problems Tuberculosis Ulcers Vein Disease

Cancer : (Please list type and Treatment) _____

_____

Other: (Please explain) _____

_____

_____

Past Surgical History: (Circle all that apply to you and list applicable dates **Check here if none _____**

Appendix_____ Back Surgery_____ Bone or Joint Surgery_____
Gallbladder_____ Hernia Surgery_____ Open Heart Surgery _____
Tonsils_____ Other: (Please explain)_____

Medications: Please list all the medications you are taking now and the dose **Check here if none_____**

1._____2._____3._____4._____
5._____6._____7._____8._____

Allergies: List the allergies to Medications <u>and the Type of Reaction</u> **Check here if none _____**

1._____2._____3._____4._____
5._____6._____7._____8._____

Circle any other allergies that apply to you.
Iodine Latex Shellfish X-ray Dye Other (Please list) _____

Past Family History: (Circle all that apply to your immediate family and indicate the family members)

Diabetes_____ Heart Attack_____Heart Disease_____
High Blood Pressure_____ Kidney Disease_____ Stroke_____
Cancer (List type)_____

Social History:

Do you use tobacco? Yes No What type: Cigarettes Smokeless

How much and for how long?_____If you quit, how long ago?_____

Do you use Street Drugs? Yes No What type, how much and how often: _____

Do you drink alcoholic beverages? Yes No If so, how much and how often?_____

Occupation:_____