

Patient's Name: \_\_\_\_\_

<p><b><u>Past Medical History:</u></b> Please list all medical illnesses that you have or had:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li><li>5.</li><li>6.</li><li>7.</li></ol>	<p><b><u>Social History:</u></b> Do you smoke?            Yes    No If yes, how much _____ Do you drink alcohol?    Yes    No If yes, how much _____ Other: _____</p>
<p><b><u>Past Surgical History:</u></b> Please list all surgical procedures that you have had (and year of surgery)</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li><li>5.</li><li>6.</li><li>7.</li></ol>	<p><b><u>Medications:</u></b> Please list all medications you are currently taking, include dose if known:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li><li>5.</li><li>6.</li><li>7.</li><li>8.</li></ol>
<p><b><u>Family History:</u></b> Please list all serious medical illnesses that exist in your immediate family:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li><li>5.</li></ol>	<p><b><u>Allergies:</u></b> List any allergies you have.</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li></ol>
<p>Physician use: (comments and notes)</p>	
<p><b><u>Diet:</u></b> Do you consume a special diet? Yes    No If yes, explain: _____</p>	