Patient's Name: _____

Past Medical History: Please list all medical illnesses that you have or had:
1.
2.
3.
4.
5.
6.
7.

Past Surgical History: Please list all surgical procedures that you have had (and year of surgery)
1.
2.
3.
4.
5.
6.
7.

Family History: Please list all serious medical illnesses that exist in your immediate family:
1.
2.
3.
4.
5.

Social History:
Do you smoke? Yes No
If yes, how much_____
Do you drink alcohol? Yes No
If yes, how much_____
Other:_____

Medications: Please list all medications you are currently taking, include dose if known:
1.
2.
3.
4.
5.
6.
7.
8.

Allergies: List any allergies you have.
1.
2.
3.

Diet: Do you consume a special diet?

Yes No

If yes,

explain:_____

Physician use: (comments and notes)