MEDICAL AND SURGICAL HISTORY

Please help us serve you better by completing your medical history before you see the Doctor. Your medical record is strictly confidential.

Name :____ Date: ____________________

Date of Birth:_______________________ Age: ________ Height:________ Weight:____________

Language: (please circle) English Spanish Other: _________________

Race: (please circle) White/Caucasian American Indian Asian Black Native Hawaiian Unknown

Ethnicity: (please circle) Hispanic Origin Non-Hispanic Origin Unknown

Reason you are seeing the doctor today: ____

How long have you had this problem:____

How many times have you been treated for this problem in the past year?________________________

What medications or tests have you received for this problem in the past?________________________

____

Medical Information

Allergic to any medications? No______ Yes______ If yes, please indicate:______________________

____

List medications you are taking now:____

____

Do you take aspirin? No______ Yes______ How often?___________________________________

List any food or environmental allergies you may have:_______________________________________

____

List all previous medical problems:____

____

____

List all previous surgeries:____

____

Social History

Do you smoke tobacco? Never___ Past ___ Present ___ Heavy Smoker ___ Light Smoker ____
Average packs per day ____ Approx start date? ___________ Approx quit date? _____________
Do you use chewing tobacco or smoke cigars? No ________Yes ________ Amount per day? _____
Do you drink alcohol?_______ Amount per day?________________________

Family History

Please list any illnesses which run in your family (list specific family members) including any bleeding disorders or bad reactions to anesthesia during surgeries.

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