

NAME: _____ DATE: _____ Referring Physician: _____

This form is intended to aid your surgeon in evaluating your past medical history. Please answer all questions as best you can.

Medications: Please list all current medicines you take, prescription and/or over the counter.

Medicine	How often	Date started	Reason
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

Your pharmacy: _____ Address: _____ Phone: _____

Allergies: Please check (v) box if allergic to any and/or list the medication that you may have an allergy to.

Medicines:	What type of reaction did you have (rash, swelling)?
1. Penicillin..... <input type="checkbox"/>	_____
2. Codeine..... <input type="checkbox"/>	_____
3. Sulfa..... <input type="checkbox"/>	_____
4. _____	_____

Medical: Have you ever had any of the following?

- | | | |
|--|--|---|
| Arthritis <input type="checkbox"/> | Lung Disease <input type="checkbox"/> | Ulcers/stomach <input type="checkbox"/> |
| Bronchitis <input type="checkbox"/> | Paralysis <input type="checkbox"/> | Breast <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Pneumonia <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> |
| Epilepsy <input type="checkbox"/> | Renal Disease <input type="checkbox"/> | |
| Gallstones <input type="checkbox"/> | Seizures <input type="checkbox"/> | |
| Heart Attack <input type="checkbox"/> | Stroke <input type="checkbox"/> | |
| Heart Disease <input type="checkbox"/> | Thyroid <input type="checkbox"/> | |
| High Blood Pressure <input type="checkbox"/> | Ulcers/leg <input type="checkbox"/> | |

Other: _____

Surgery: Please check (v) box if applicable; also list date and name of hospital and/or surgeon if known.

- | | |
|--|-------|
| Appendix <input type="checkbox"/> | _____ |
| Breast Right Left <input type="checkbox"/> | _____ |
| Colon <input type="checkbox"/> | _____ |
| Gallbladder <input type="checkbox"/> | _____ |
| Heart <input type="checkbox"/> | _____ |
| Hemorrhoids <input type="checkbox"/> | _____ |
| Hernia repair <input type="checkbox"/> | _____ |
| Hysterectomy <input type="checkbox"/> | _____ |