

WESTERN SURGICAL GROUP

Name: _____ Age: _____ Date: _____

Referring Physician: _____ Birth Date: _____

Your answers on this form will help your doctor understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or dates.

Past Medical History

Please indicate whether you have had any of the following medical problems.

Heart Disease:

Specify Type _____

Heart Attack

High Blood Pressure

Diabetes

High Cholesterol

Thyroid Problem

Stroke

Specify Type _____

Bleeding/Clotting Problem

Blood Transfusion

Cancer (Malignancy)

Specify Type

Depression/Suicide Attempt

Alcoholism

Other problems: (specify)

Past Surgical History

Please list other previous surgical procedures, hospitalizations, injuries or other prior medical events

Allergies

Do you have any allergies? (include medication, environmental, chemical, latex, betadine)

If yes, please indicate:

Medications

List all current medications you are taking and their dosages (prescription, e.g. hormone replacement therapy, vitamins, herbs, and all over the counter drugs)

Medication	Dose	Frequency (how often you take the medicine)

Family History

Medical Condition	N	Y	Affected Relative
Anesthesia problem			
Bleeding disorder			
Cancer			
Heart Disease			
Diabetes			
High blood pressure			
Seizure			
Stroke			
Substance abuse			

Social History

Marital Status?

Number of Children? _____ Ages? _____

Education level completed _____

Current Occupation _____ Employer _____

Current employment status?

Tobacco Use

Cigarettes? _____ How many cigarettes do you or did you smoke per day? _____

Pipe, Cigar, Chew?

Alcohol Use: Average number of drinks per month? _____

Drug Use?

IV drug use?