Patient Name ___________________________________ **Past Medical History** Date_________________

Please check any condition you have or have had. ☐No medical history to report

☐Allergies
☐Anemia
☐Anxiety
☐Arthritis
☐Asthma
☐Blood transfusion
☐Cancer
☐Congestive Heart Failure
☐Nerve/Muscle Disease

☐Lung disease
☐Meningitis
☐Depression
☐HIV/AIDS
☐Kidney Disease
☐Diabetes mellitus
☐Clotting Disorder (blood clot)
☐High Blood Pressure

☐Acid Reflux
☐Glaucoma
☐Gout
☐Heart Attack
☐High Cholesterol
☐Osteoporosis
☐Seizures
☐Sickle Cell Anemia

☐Stroke
☐Substance Abuse
☐Thyroid disease
☐Tuberculosis
☐Ulcers
☐Anesthetic Complications
☐Cataracts
☐Other:_________________________

Past Surgical History

Please check any surgery you have had. ☐Never had surgery

☐Appendix
☐Brain Surgery
☐Breast Surgery
☐Open Heart or Bypass Surgery
☐Gall Bladder

☐Colon Surgery
☐Fracture Surgery
☐Hernia Repair
☐C-Section
☐Eye Surgery

☐Hysterectomy
☐Joint Replacement
☐Small Intestine Surgery
☐Spine Surgery
☐Tubes Tied

☐Heart Valve Replacement
☐Cosmetic Surgery
☐Orthopaedic Surgery ______________
☐Other:__________________________

Social History

Please check all that apply

☐Current Every Day Smoker
☐Current Some Day Smoker
☐Former Smoker
Quite Date ______________

☐Never Smoker
☐Passive Smoker (2nd Hand Smoke)
☐Vaping

☐Alcohol: Drinks/week
_____ Glasses of wine
_____ Cans of Beer
_____ Shots of Liquor
_____ Drinks containing 0.5oz of alcohol

☐ Drug use: Uses/week ____________
☐Marijuana
☐Cocaine
☐Methamphetamines
☐IV

Family Medical History

Please write in any medical condition or disease that has been in your family

Disease	Family Member(s)		Disease	Family Member(s)

Current Medications ☐No medications

Medication	Strength	How Often?

Medication Allergies ☐No known medication allergies

Medication	Reaction		Medication	Reaction

Primary Care Provider: ________________________________ Pharmacy: ____________________________________