SURGICAL CARE P.C.
Patient Medical History

Date of Service: _____

Full Name: _____ **Nick Name:** _____ **Date of Birth:** _____
Occupation: _____ Spouse: _____ Spouse Occupation: _____
Children: _____

List any medications to which you are allergic and circle the reaction you experienced:

1. _____ Rash/Hives Swelling Shock Difficulty breathing
2. _____ Rash/Hives Swelling Shock Difficulty breathing
3. _____ Rash/Hives Swelling Shock Difficulty breathing

Are you allergic to Latex? **YES/NO** Diagnosed with MRSA(skin infection)? **YES/NO**
Diagnosed with Diabetes? **YES/ NO** If YES, Type I or Type II Insulin Dependent? **YES/ NO**
Do you have a Pacemaker? **YES/NO** If YES, Brand/ Type _____
Pharmacy Name & Location: _____

List all prescription & OTC meds/hormones you currently take:

	NAME	DOSAGE/ TIMES PER DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

List all operations you have had to date:

	SURGERY	HOSPITAL / YEAR
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Do you drink alcohol: ___No ___Yes (Socially___ Weekly___ Daily___)
Do you use tobacco: ___No ___Yes Packs per day? _____ How many years? _____ If quit, how long ago? _____
Drug/ alcohol abuse: ___No ___Yes Treatment: ___No ___Yes
Have you used Aspirin, Ibuprofen, Advil, Aleve or Motrin in the last 7 days? ___No ___Yes

FAMILY HISTORY:

	Living	Deceased	Cause of Death
Father			
Mother			
Sisters	No#_____	No#_____	
Brothers	No#_____	No#_____	

Have you or a family member ever experienced: Anesthesia Problems ___No___Yes Bleeding Problems ___No___Yes

Please check if you have a family history of any of the following and indicate the family member who had it:

___Breast cancer: _____ Other cancers: _____
___Colon cancer: _____ Stroke / Heart attack: _____
___Lung cancer: _____ Diabetes: _____
___Ovarian cancer: _____

Patient Signature: _____ Date: _____