

MEDICAL/SURGICAL PATIENT HISTORY

Name: _____

Date: _____

Medical / Psychiatric problems and year diagnosed:

_____	_____
_____	_____
_____	_____

Surgeries and year performed:

_____	_____
_____	_____

All current medications: (prescription, over-the-counter, herbal/vitamins and doses)

_____	_____
_____	_____
_____	_____

Other physicians caring for you (please include phone #)

_____	_____
_____	_____

Allergies (medicine and/or food):

_____	_____
_____	_____

Smoke: Y/N

Packs/day:

Year quit:

Alcohol: Y/N

Drinks/day:

Year quit:

Substance abuse: Y/N What substance(s):

Year quit:

Caffeine intake/day:

Are you experiencing any physical or emotional abuse? Y/N

List family members who have had: Heart attack, chest pain, stroke, congestive heart failure, arrhythmia, fainting, unexplained death (please include their age when diagnosed):

