Medical & Surgical History

Please complete all fields, save this file, and email it back to us — or print and bring it to your visit.

PATIENT INFORMATION

Patient Name

Today's Date

Date of Birth

Primary Care Physician

PCP Phone

PAST MEDICAL HISTORY — CHECK ALL THAT APPLY

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Cancer ☐ Depression / Anxiety ☐ Asthma / COPD

☐ Kidney Disease ☐ Liver Disease ☐ Stroke ☐ Thyroid Disease ☐ Autoimmune Disease ☐ Seizure Disorder

Other conditions / details:

-
-

PAST SURGICAL HISTORY

List all prior surgeries with the approximate year.

-
-
-
-
-

FAMILY HISTORY

Mother's health history

Father's health history

Sibling(s) health history

SOCIAL HISTORY

Occupation

Work Status

☐ Working full-time ☐ Working part-time ☐ Disabled ☐ Retired ☐ Unemployed

Smoking

☐ Never ☐ Former ☐ Current

If current/former, packs per day & years

Alcohol Use

☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

Recreational Drug Use

☐ Yes ☐ No

SIGNATURE

I confirm the above information is accurate and complete to the best of my knowledge.

Patient Signature (type full name)

Date