SURGICAL HISTORY AND MEDICAL INFORMATION

PATIENT NAME: ____________________________

What medicines or drugs are you allergic to? ____

____

____

Any other allergies? (Latex, tape, environmental, etc.) ______________________________

____

List all past surgeries:

____

____

____

____

Has any family member seen one of our Doctors? Is so, please give family member's name and the Doctor seen.

____

____

What medicines or drugs are you presently taking? Please list the name and the dosage.

NAME	DOSAGE	NAME	DOSAGE

Do you smoke? ________________________ If so, how much? ______________________________

Do you drink alcohol? ___________________ If so, how much? ______________________________

Use additional space for any other information you feel is important for the Doctor to know?

____

____

____

____

____

____

____

SIGNATURE ______________________________________ **DATE**__________________________________