Brief History

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last name:	First:	Age:	Sex:	Doctor Notes *Please do no write in this area*

Presenting problem or proposed surgery:

ILLNESS/INJURY: Please check if you have ever had:

Yes	No		Yes	No	
		High blood pressure			Kidney stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart attack			Thyroid problem
		Chest pain/tightness			Lung problems/asthma
		History of heart murmur			Shortness of breath
		Stroke			Accidents/broken bones (list)
		Cancer			
		Hepatitis			
		Yellow jaundice			
		Gallstones			

OPERATIONS: List names and dates of all operations have you have ❑ None

Year	Name of operation	Type of anesthetic, if known	Complications

Have you ever had a blood transfusion? ❑ Yes ❑ No Date: ___________

List any hospital admissions or medical conditions not listed above:

FEMALES ONLY: Are you pregnant? ❑ Yes ❑ No

DRUGS: Please list all drugs you take and their dosages.			❑ None	Doctor Notes *Please do no write in this area*
Drug	Dosage	Drug	Dosage	
ALLERGIES: Please list type and reaction.			❑ None	
Name of drug	Reaction	Name of drug	Reaction	

Do you now use tobacco? ❑ Yes ❑ No Day # Yrs _____/_____

Have you ever used tobacco? ❑ Yes ❑ No Yrs quit_____________

Do you drink alcohol? ❑ Yes ❑ No Day # Yrs _____/_____

Have you ever used alcohol? ❑ Yes ❑ No Yrs quit_____________

Type: ___________________________

The above information is true and accurate.

Patient signature (parent if patient is a minor):___________________________