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Name: _____

Past Surgeries & Dates:

Social History

Alcohol	Never	Social	Frequent	Type?	Quit?/When?
Drug use	Never	Occasional	Frequent	Type?	Quit?/When?
Exercise	Never	Occasional	Moderate	Heavy	
Tobacco	Never	Packs/Day		Smokeless	Quit/When?
Military	Active	Inactive	None		
Marital Status	Single	Married	Divorced	Widowed	

Immediate Family Medical History (circle all that apply)

High Blood Pressure	Yes	No	HIV/AIDS	Yes	No
Respiratory Problems	Yes	No	Heart Trouble	Yes	No
Bleeding Problems	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Other Problems:_____		
Stroke	Yes	No			

Patient Medical History (circle all that apply)

Abdominal Problems	Yes	No	Hepatitis	Yes	No
Anesthesia Problems	Yes	No	Hormone Abnormalities	Yes	No
Asthma	Yes	No	Hypertension	Yes	No
Bleeding Problems	Yes	No	Kidney Stones/Disease	Yes	No
Blood Clots	Yes	No	Lung Disease	Yes	No
Bowel Problems	Yes	No	Muscle Disease	Yes	No
Breast Lumps/Pain	Yes	No	Neurologic Disease	Yes	No
Bronchitis	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Wound Healing Issues	Yes	No
Cataracts	Yes	No	Diabetic	Yes	No
Convulsions/Seizures	Yes	No	Other: _____		
Coronary Artery Disease	Yes	No			
Gerd	Yes	No			
Heart Disease	Yes	No			