



Name: \_\_\_\_\_



Date of birth: \_\_\_\_\_

**Past Surgical History**

Have you ever had any problems with anesthesia?  Yes  No Explain: \_\_\_\_\_

Surgery	Year	Complications

**Family History**

Do any of your grandparents, parents, siblings, or children have any of the following diseases? Please explain.

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Back or neck problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Migraines/headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Psychiatric problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

**Social History**

Marital status:  Single  Married  Divorced  Separated  Widowed

Do you live alone?  Yes  No

Employed (occupation \_\_\_\_\_)  Student  Retired

Children?  Yes  No Number: \_\_\_\_\_

Exercise?  Never  Rarely  Weekly  Daily

What type of exercise? \_\_\_\_\_

Smoking?  Yes  No \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.

Quit smoking?  Yes  No When? \_\_\_\_\_

Previously smoked?  Yes  No \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.

Chew tobacco?  Yes  No How much? \_\_\_\_\_

Drink alcohol?  Yes  No How much and how often? \_\_\_\_\_

Substance abuse?  Yes  No What? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

MD Signature \_\_\_\_\_ Date \_\_\_\_\_