HOPE SURGICAL PLLC

PAST MEDICAL HISTORY

NAME: _____ SEX: _____ AGE: _____ BIRTHDATE: _____

Past Medical History. Have you ever been diagnosed with the following conditions?

Please circle and state year of onset.

Alcoholism	Colitis	High Cholesterol	Prostate Disease
Addiction	Depression	High Blood Pressure	Seizures
Anemia	Diabetes	Hives/Eczema	Thyroid Disease
Angina	Gallbladder Disease	Kidney Disease	Tuberculosis
Arthritis	Glaucoma	Migraines	Ulcers
Asthma/Hay Fever	Gout	Osteoporosis	Urinary Infection
Blood Transfusion	Heart Problem	Pancreatitis	Hepatitis
Pneumonia	Cancer of:		
Other:			

Current Medications:

- _____
- _____
- _____

Have you had any surgeries? (Please list type of surgery and year it was performed.)

- _____
- _____
- _____

Please list any allergies you have and the reaction.

- _____
- _____
- _____

Family History: Has any member of your family (parents, brothers, sisters) had any of the following?

Please circle who in the family.	Father	Mother	Sibling
Diabetes	F	M	S
Heart Disease	F	M	S
High Blood Pressure	F	M	S
Osteoporosis	F	M	S
Stroke	F	M	S
Thyroid Disease	F	M	S
Reproductive Difficulty	F	M	S
High Cholesterol	F	M	S
Obesity	F	M	S

Do you smoke? YES /N Packs per day? _____ Former Smoker? YES/NO Year Quit? _____

Do you drink alcohol beverages? YES/NO How much? _____

Do you exercise? YES/NO How often? _____

Date of last FLU Shot? _____