MEDICAL HISTORY

Surgical Associates, P.C. (Rev. July 15, 2004)

Name	Date of Birth	Age	Today's Date

PLEASE PRINT

1. List allergies or sensitivities to any medications or substances such as Penicillin, Codeine, Novacaine, Xylocaine, Epinephrine, Latex, etc. If no known allergies, write NKA.

   ______________________ ______________________ ______________________

2. List all medications you take daily.

   ______________________ ______________________ ______________________

   ______________________ ______________________ ______________________

3. Do you take Coumadin, Plavix, Aspirin or other blood thinners? □ No □ Yes

4. Do you smoke? □ No □ Yes. How much? ______________ For how long? ______________

   Do you drink alcoholic beverages? □ No □ Yes. How much? ______________________________

5. Have you ever had any of the following?

Anemia	High Blood Pressure	Seizures
Poor Circulation	HIV/HTLV Infection	Stroke
Diabetes	Menstrual Problems	Ulcer Disease
Heart Problems	Mitral Valve Prolapse	Respiratory Problems
Hepatitis	Cancer If yes, what kind?	
Other		

6. Describe any surgery you have had in the past:

Date of surgery	Type of Procedure	FOR OFFICE USE ONLY

7. If you have a family history of the following, indicate what relation to you. If none, leave blank.

Breast Cancer	Cancer
Diabetes	Heart Disease
High Blood Pressure	Tuberculosis