SURGICAL CONSULTING PLLC - GENERAL INFORMATION

Age: _____ Occupation: _____ Married: yes☐ no☐ # children _____

HABITS:

Alcohol consumption	yes☐	no☐	# glass / day, type _____
Coffee consumption	yes☐	no☐	# cups / day _____
Ever used tobacco?	yes☐	no☐	# packs / days _____
Ever used street drugs?	yes☐	no☐	
Special diet?	yes☐	no☐	Specify _____

FAMILY HISTORY

History of Diabetes☐ High Blood Pressure☐ Cancer☐
Heart Disease☐ Inherited Diseases☐

Father living / deceased:	Age _____	Medical Problems: _____
Mother living / deceased:	Age _____	Medical Problems: _____
Sisters # living:	Deceased _____	Medical Problems: _____
Brothers # living:	Deceased _____	Medical Problems: _____

CHRONIC HEALTH PROBLEMS: (indicate if YES)

None known☐ High Blood Pressure☐ Cancer☐
Diabetes☐ Arthritis☐ Stroke☐
Heart Disease☐ Stomach Ulcers☐ Other _____

PREVIOUS SURGERY:

TYPE: _____ DATE: _____ TYPE: _____ DATE: _____
TYPE: _____ DATE: _____ TYPE: _____ DATE: _____
TYPE: _____ DATE: _____ TYPE: _____ DATE: _____
TYPE: _____ DATE: _____ TYPE: _____ DATE: _____

ALLERGIES: (FOOD, DRUG)

1. _____
2. _____
3. _____

MEDICATIONS: (Name, Dosage, Number of times per day taken)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

CHILDHOOD ILLNESSES: Rheumatic Fever☐ Asthma☐ Epilepsy☐

REASON FOR COMING TO THE OFFICE:

_____
_____
_____

NAME: _____ TODAYS DATE: _____