PATIENT HISTORY QUESTIONAIRE
GENERAL SURGERY

Name:_____ Date of Birth:_____

PAST HISTORY: Circle if you have or have had any of the following:

Rheumatic Fever
High Blood Pressure
Gout
Emphysema
Asthma
Hay Fever
Frequent Infections
Ulcers
Angina
Heart Attack
Anemia
Diabetes
Nervous Breakdown
Gall Bladder Disease
Blood Transfusions
Thyroid Disease
Cancer
Kidney Disease
Jaundice
HIV/AIDS
Bleeding Problems
Stroke

How much do you smoke a day? _____ How old were you when you started? _____

What is your average weekly alcohol intake? _____

Do you or have you ever used recreational drugs? _____

What medications do you take regularly? Please include over-the-counter drugs.

_____ _____

_____ _____

_____ _____

_____ _____

List any medications you are ALLERGIC to: _____

Are you ALLERGIC to latex? Yes _____ No _____

What operations have you had in the past? Please list why and when:

_____

_____

_____

Have you ever had a problem with anesthesia? If so, what kind of problem?

_____

When was your last tetanus shot? _____

FAMILY HISTORY: Circle if any blood relatives has or has had any of the following:

Stroke
Cancer
High Blood Pressure
Tuberculosis
Bleeding Problems
Migraine
Asthma
Emphysema
Diabetes
Arthritis
Alcoholism
Hay Fever
Heart Attack
Angina

Patient Signature:_____ Date: _____