

Date: _____

Patient Name: _____

Date of Birth: _____

Past Medical History

Allergy: _____

What reaction do you get with this allergy? _____

List any medications you are taking:

Past surgeries and dates:

Do you have or have you had any of the following? (please circle all that apply)

Kidney	Yes	No
Heart	Yes	No
Lung	Yes	No
Liver problems	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Tuberculosis	Yes	No
Thyroid Disease	Yes	No
Rheumatic fever	Yes	No

Social History

Smoke	Yes	No
Former Smoker	Yes	No
Drink	Yes	No
Wine With Meals	Yes	No
Excessive Drinker	Yes	No

Does anyone in your family have Diabetes? If so who in the family has it and on what side of the family?
