

CAPITAL SURGEONS GROUP, PLLC

PATIENT HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____ DATE: _____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY

PREVIOUS SURGERIES

TYPE: _____ DATE: _____

TYPE: _____ DATE: _____

TYPE: _____ DATE: _____

TYPE: _____ DATE: _____

PREVIOUS HOSPITALIZATIONS

REASON: _____ DATE: _____

REASON: _____ DATE: _____

REASON: _____ DATE: _____

REASON: _____ DATE: _____

MEDICAL ILLNESSES

	<u>PATIENT</u>		<u>FAMILY</u>		FAMILY MEMBER: _____
	YES	NO	YES	NO	
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SPECIFY TYPE OF CANCER					_____
OTHER ILLNESSES					_____

CURRENT MEDICATIONS (Including HERBS, VITAMINS, SUPPLEMENTS & OVER-THE-COUNTER MEDICINE)

NAME: _____	DOSAGE: _____	NAME: _____	DOSAGE: _____
NAME: _____	DOSAGE: _____	NAME: _____	DOSAGE: _____
NAME: _____	DOSAGE: _____	NAME: _____	DOSAGE: _____
NAME: _____	DOSAGE: _____	NAME: _____	DOSAGE: _____

DRUG & FOOD ALLERGIES

DRUG/FOOD: _____ REACTION: _____

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DRUG/FOOD: _____ REACTION: _____

DRUG/FOOD: _____ REACTION: _____

DRUG & FOOD ALLERGIES

DRUG/FOOD: _____ REACTION: _____

DRUG/FOOD: _____ REACTION: _____

DRUG/FOOD: _____ REACTION: _____

DRUG/FOOD: _____ REACTION: _____

HABITS

Have you ever smoked tobacco? _____ If yes: How long / how much? _____ When did you quit? _____

How often do you consume alcohol? _____ How much caffeine do you consume? _____

Have you ever used IV street drugs? _____ How often do you exercise? _____

SOCIAL

Married
 Divorced
 Single
 Widowed

Occupation: _____

Level of Education: _____

SIGNATURE

DATE