**SURGICAL ASSOCIATES OF NEW HAVEN, P.C.**
**PATIENT MEDICAL HISTORY FORM**

Name: _____ Date: _____

Name of Primary Physician: _____ Date of Birth: _____

Name of Referring Physician (if different): _____ Age: _____

I. For what problem are you being seen at this time?

Have there been previous problems in this area? Yes No

II. Occupation:_____

III. List all medical conditions for which you currently see or have seen a doctor.

| | Problem | Doctor | Date(s) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

IV. What medicines (prescription and non-prescription) do you take?

| | Name | Dose | How often | Indication (Reason taken) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

V. Are you allergic to any drugs or other agents?

| | Allergic to What? | What happens? |
|---|---|---|
| 1. | | |
| 2. | | |

VI. List all previous operations. Any problem with bleeding or anesthesia? Surgical complications?

| | Operation | Surgeon | Date | Postoperative Problem/Complications |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

PLEASE TURN OVER

Name: _____ DOB: _____

VII. List all hospitalizations.

| | Date | Hospital | Doctor | Problem |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

VIII. List family history. Note particularly cancer, heart disease, diabetes, bleeding problems, problems with anesthesia.

| | Relative (father, sister, etc.) | Problem |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

IX. Do you have sleep apnea? Yes No If yes, do you use a CPAP machine. Where and when evaluated?_____

X. Have you ever had a blood transfusion? Yes No

If so, when and why: _____

XI. Do you smoke? _____ Did you ever smoke? _____ How many packs per day? _____For how Long? _____

XII. Do you drink alcohol? _____ Did you ever? _____ How many drinks per week? _____

XIII. Who lives at home with you?

XIV. Any major stresses or changes in your life or lifestyle in the last one or two years?

XV. **For Women**:

Date of last menstrual period: _____

Age of first menstrual period: _____

Number of pregnancies: _____

Age at time of first pregnancy: _____

Number of children: _____

Date of last mammogram: _____

Patient Signature: _____

Physician Signature: _____

Date: _____