

METROPLEX SURGICAL SPECIALISTS
PERSONAL HISTORY

Patient Name: _____ DOB: _____

Referred By: _____ Other Consultants: _____

Chief Complaint: _____

HISTORY OF PRESENT ILLNESS		ALLERGIES
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MEDICAL HISTORY		SOCIAL HISTORY
Diabetes Yes No _____ High Blood Pressure Yes No _____ Cancer Yes No _____ Stroke Yes No _____ Heart Trouble Yes No _____ Arthritis / Gout Yes No _____ Lung Problems Yes No _____ Bleeding Tendency . Yes No _____ Acute Infections Yes No _____ Venereal Disease ... Yes No _____ Other Yes No _____ LMP Yes No _____	Married _____ Single _____ Widowed _____ Divorced _____ Separated _____ Work _____ Tobacco Use: Never _____ Previously, but quit _____ Packs / Year _____ Alcohol Use: Never _____ Rarely _____ Moderate _____ Daily _____ Quit _____	
PRIOR SURGERY OR TRAUMA HISTORY		MEDICATIONS
Year _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
FAMILY HISTORY		HERBS
Diabetes Yes No _____ High Blood Pressure . Yes No _____ Cancer Yes No _____ Stroke Yes No _____ Heart Trouble Yes No _____		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Patient's Signature _____ Date _____