MCC SURGICAL GROUP

Patient Name:_____ Date of Birth:_____Age:_____

Past Medical History—Please check ALL items that apply to you.

[ ] Heart Disease	[ ] Psychiatric Illness	[ ] Ulcers	[ ] Osteoporosis
[ ] Liver Disease	[ ] Lung Disease	[ ] Osteoarthritis	[ ] Diabetes
[ ] Seizures/Epilepsy	[ ] Thyroid Disease	[ ] Rheumatoid Arthritis	[ ] Bowel Disorders
[ ] High Cholesterol	[ ] Kidney Disease	[ ] Acid Reflux	

Cancer (please specify)_____

Other (please specify)_____

[ ] None

Past Surgical History—Please check ALL items that apply to you.

[ ] Lumbar Spine/ Low Back	[ ] Cervical Spine/ Neck	[ ] Heart	[ ] Lung
[ ] Kidney	[ ] Bowel	[ ] Hernia	[ ] Gallbladder
[ ] Extremities/ Arms or Legs	[ ] Breast	[ ] Prostate	[ ] Hysterectomy

[ ] Other (please describe) _____

_____

[ ] None

Allergies—Please list ALL allergies or anything you have had a reaction to:

_____

_____

Current Medication: **Dosage:** **Frequency:**

(Please see reverse side for more space)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History--Please check any disease diagnosed in your immediate family and with whom:

	Grandmother	Grandfather	Mother	Father	Brother	Sister	Children
Cancer							
Diabetes							
Heart Disease							
Stroke							
Bowel Disorder							
High Blood Pressure							

Other (please specify) _____

Social History—Please answer all questions:

Do you smoke? [ ] Yes [ ] No If yes, how much? _____

Have you ever smoked? [ ] Yes [ ] No If yes, number of years ago _____

Do you drink alcohol? [ ] Yes [ ] No If yes, how often? _____

Do you use illegal drugs [ ] Yes [ ] No If yes, how often? _____

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MEDICATION LIST

Current Medication:	Dosage:	Frequency: