Pre-Surgical Medical History Form

Patient Information

Full Name

Date of Birth

Sex

Address

Phone Number

Email Address

Medical History

Allergies (medications, latex, foods, etc.)

Current Medications (include dosage and frequency)

Previous or Current Medical Conditions

Previous Surgeries or Hospitalizations

Family History of Medical Conditions

Lifestyle

Do you smoke?

Do you consume alcohol?

Other Substance Use

Other Information

Are you currently pregnant?

Additional Notes or Concerns