Suffolk Surgery Center

Patient Medical History Form - Page 1

This form should be completed prior to your appointment at Suffolk Surgery Center and brought with you at your appointment. The form can be filled out on screen and then printed out or printed out first and then completed by hand.

PERSONAL INFORMATION

PATIENT'S LAST NAME: FIRST NAME: MIDDLE INITIAL:

ADDRESS:

CITY: STATE: ZIP CODE:

EMAIL ADDRESS: PRIMARY LANGUAGE:

SEX: ☐ M ☐ F MARITAL STATUS: AGE: DATE OF BIRTH:

HOME PHONE: WORK PHONE: CELL: FAX:

SOCIAL SECURITY #:

PRIMARY PHYSICIAN:

ALLERGIES:

☐ NO KNOWN ALLERGIES ☐ LATEX

EMERGENCY CONTACT NAME: RELATIONSHIP:

PHONE NUMBERS:

MEDICAL HISTORY - Additional Space on Page 2

DIABETES ☐ TYPE 1 ☐ TYPE 2

HIV

HEPATITIS

CARDIAC

HYPERTENSION

RESPIRATORY/ASTHMA/COPD (LUNGS)

GASTRO-INTESTINAL

GENITO-URINARY

LIVER PROBLEMS

KIDNEY PROBLEMS

NEUROLOGICAL/SEIZURES

CONTAGIOUS DISEASES

PAST SURGICAL HISTORY

BLEEDING DISORDERS

ARTHRITIS

CANCER

RECENT ILLNESS

SUBSTANCE USE

SMOKING

PACEMAKER/ ICD

IF YES, WHEN WAS IT CHECKED LAST

PREGNANT

GLASSES

HEARING AID

(Please go to page 2)

Suffolk Surgery Center

Patient Medical History Form - Page 2

ADDITIONAL PERTINENT INFORMATION

CURRENT PRESCRIPTION MEDICATIONS:

MEDICATION	DOSAGE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

NON PRESCRIPTION MEDICATIONS AND DOSAGES:

MEDICATION	DOSAGE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

SIGNATURE OF PATIENT **DATE SIGNED**

SIGNATURE OF GUARDIAN IF INDICATED **DATE SIGNED**