



**PREVIOUS SURGERY:**

Please list any previous surgeries you may have had.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

**FAMILY HISTORY:**

Do any of your family members have any of the following:

	Yes	No		Yes	No		Yes	No
Breast Cancer			Diabetes			Heart Disease		
Melanoma			Stroke			Kidney Disease		
Other Cancer			High Blood Pressure			Depression		
Bleeding problems			Anesthesia problems			Blood clot problems		
Arterial Disease			Varicose veins					

**MEDICATIONS:**

Please list any prescription, non-prescription, and herbal medications you are taking. If you have a long list, please provide it for us to copy.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_
- 11. \_\_\_\_\_
- 12. \_\_\_\_\_

**SOCIAL HISTORY:**

Do you Smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how many packs per day? \_\_\_\_\_

If you smoked in the past, when did you quit? \_\_\_\_\_

On average, how many alcoholic drinks do you have per week? \_\_\_\_\_

Have you had problems with substance abuse? \_\_\_\_\_ if so, please describe \_\_\_\_\_

\_\_\_\_\_

