Surgical Associates of La Jolla
PERSONAL HISTORY

Patient's Name ______________________________ Today's Date _______________
Date of Birth ______________________________ Age _______ Sex ________
Referred by: ______________________________ Marital status _______________
Occupation ______________________________ Employer _______________

CHIEF COMPLAINT- Please describe the reason for your visit today:

____

MEDICATIONS- please list **Name**, **Strength** (dose), and **Frequency** (number of times taken daily):

1. ____
2. ____
3. ____
4. ____
5. Do you take Aspirin every day? ________ (If yes, dose ____)

ALLERGIES- include all allergies:

Do you have any allergies to medications? ____ Yes ____ No

If so, please list: ____

Other: ____ Iodine?_____ Shellfish?_____

SURGICAL HISTORY- Please list any prior surgeries chronologically (include year):

1. ____
2. ____
3. ____
4. ____
5. ____

MEDICAL HISTORY- Have you ever had any of the following? When?

Asthma	___ Yes	___ No	Rheumatic fever	___ Yes	___ No
Diabetes	___ Yes	___ No	Seizures	___ Yes	___ No
Heart attack	___ Yes	___ No	Strokes	___ Yes	___ No
High blood pressure	___ Yes	___ No	Tuberculosis	___ Yes	___ No
Pneumonia	___ Yes	___ No	Thyroid disorder	___ Yes	___ No

Cancer? ___ Yes ___ No If yes, what type? ____________________________________

Please list any other illness or hospitalizations: ______________________________________

____

******(Please see reverse to complete additional information)******

PERSONAL HABITS:

Do you currently smoke? ___ Yes ___ No If yes, for how long? ________ packs/day ___

Did you smoke in the past? ___ Yes ___ No If yes, for how long? ________ packs/day ___

Do you drink alcohol? ___ Yes ___ No Drinks per week? _________

Do you use drugs? ___ Yes ___ No If yes, what type? _________

Do you consume caffeine in the following?

Coffee? ___ Yes ___ No If yes, cups per day ___

Tea? ___ Yes ___ No If yes, cups per day ___

Soda? ___ Yes ___ No If yes, cups per day ___

Chocolate? ___ Yes ___ No

FAMILY HISTORY:

RELATION AGE AGE AT DEATH STATE OF HEALTH OR CAUSE OF DEATH

Mother: ____

Father: ____

Brothers ____

& Sisters: ____

____

____

____

Children: ____

____

____

____

____

Patient Signature:_________________________ Date:______________

Doctor Signature:_________________________ Date:______________