Surgical Associates of La Jolla

Personal History

Patient's Name:	Date of Birth:	Today's Date:

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

MEDICATIONS – Please list the name, strength, and number of times taken daily:

		Do you take Aspirin every day?

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.	4.	7.
2.	5.	8.
3.	6.	9.

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

Asthma ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Heart attack ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No
Rheumatic fever ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Strokes ☐ Yes ☐ No	Tuberculosis ☐ 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	If yes, cups per day _____

FAMILY HISTORY:

Relation	**Age**	**Age at death**	**State of health / Cause of death**
Mother:			
Father:			
Brothers & Sisters:			
Children:			

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____