ASA
ADVANCED SURGICAL ASSOCIATES

Date: _____

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

CHIEF COMPLAINT – Why you are here today? _____

PAST MEDICAL HISTORY: _____

_____

PAST SURGICAL HISTORY *(Please include EGD/colonoscopy dates)*: _____

_____

_____

HOSPITALIZATIONS: _____

_____

MEDICATIONS AND DOSAGE *(Including aspirin and over the counter medications)*

MEDICATION NAME	DOSAGE		MEDICATION NAME	DOSAGE

ALLERGIES AND REACTIONS: _____

_____

PATIENT SOCIAL HISTORY

Smoker? ☐Yes ☐ No
How many packs daily? _____
How many years? _____
Interested in stopping? ☐Yes ☐ No

Do you smoke marijuana? ☐Yes ☐ No

Alcohol Use? ☐Yes ☐ No
Type: _____
Amount: _____

Do you have an Advanced Directive?
DNR DNI Living Will

Trouble sleeping? ☐Yes ☐ No
Do you snore? ☐Yes ☐ No
Daytime drowsiness? ☐Yes ☐ No

Marital status? _____

Type of Employment:
_____

Exercise? ☐Yes ☐ No
Type: _____
Duration: _____

FEMALE PATIENTS ONLY:

Regular periods? ☐Yes ☐ No ☐ Varies

Complication wit pregnancy? ☐Yes☐ No
Are you pregnant now? ☐Yes ☐ No

Have you had a hysterectomy
☐Yes ☐ No

Last menstrual period: _____

Date of last mammogram: _____

FAMILY MEDICAL HISTORY: _____

_____