CAPE COD SURGICAL ASSOCIATES

PATIENT HISTORY

Name: _____ Date of birth: _____ Today's date: _____

Referring physician: _____ PCP (if not referring physician):_____

Current illness, i.e. why are you seeing the doctor today? _____
_____

What testing (labs, x-ray's, etc.) have you had done? _____

PAST MEDICAL HISTORY

List all PAST and PRESENT serious illnesses and medical conditions (diabetes, heart attack, stroke, hypertension, cancer):
_____
_____
_____

List all previous OPERATIONS and dates: _____
_____
_____

List all your current MEDICATIONS, dosages and how many times a day you take them; please include all over-the-counter medications, eyedrops, vitamins, and supplements: ☐ I have a list with me

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all ALLERGIES (including medications, latex, iodine, shellfish): _____
_____
_____

SOCIAL HISTORY

Do you smoke cigarettes, cigar, pipe? How much? _____ If you quit, when? _____

Do you drink alcohol?_____ How much? _____

Marital Status: Married Divorced Single Separated Widowed

# of pregnancies_____ # of children _____ Occupation: _____

FAMILY HISTORY

List all serious illnesses in your immediate family (diabetes, heart attack, stroke, hypertension, cancer, etc…):

Mother: _____ Father: _____ Maternal grandparents: _____

Brothers: _____ Sisters: _____ Paternal grandparents: _____

I have received a copy of the practice's Notice of Privacy Practices.

Signature (patient or parent of minor): _____ Date: _____

Print Name: _____