BAYOU SURGICAL SPECIALISTS, LLC

PATIENT MEDICAL HISTORY FORM

Name: _____ Age: _____ Date: _____

Birthdate: _____ Height: _____ Family Doctor:_____

ALLERGIES □ NO ALLERGIES

□ Penicillin
□ Sulfa
□ IVP Dye
□ Latex Allergy
Other Allergies: _____
_____

PRESENT MEDICATIONS

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

□ Acid Reflux
□ Anemia
□ Arthritis
□ Asthma
□ Breast Condition _____
□ Cancer _____
□ Colon Polyps
□ Diabetes
□ Diverticulosis
□ Gout
□ Heart Attack or Heart Condition
□ Hemorrhoids
□ Hiatal Hernia
□ Increased Blood Pressure
□ Kidney Stone
□ Mitral Valve Prolapse
□ Prostate
□ Stroke
□ Thyroid Condition
□ Tuberculosis
□ Other Medical Conditions: _____

SURGERIES

□ Angioplasty
□ Appendectomy
□ Breast Biopsy
□ Cesarean Section
□ Eyes
□ Gallbladder
□ Heart Bypass
□ Hemorrhoidectomy
□ Hernia
□ Hysterectomy
□ Ovaries Removed
□ Pacemaker
□ Tonsils / Adenoids
□ Tuberculosis

Other surgeries :

_____
_____
_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

* Please note which family member
□ Cancer (what kind?) _____
_____
_____
□ Diabetes _____
□ Heart Condition _____
□ Other: _____

SOCIAL HISTORY

□ Current smoker
□ Past smoker
□ Never