Pre-Surgical Medical History Assessment Form

Patient Information

Full Name

Date of Birth

Gender

Select

Phone Number

Email Address

Medical History

Please list any current or past medical conditions

List any allergies (medications, foods, etc.)

Current medications (including supplements)

Surgical & Anesthesia History

Previous surgeries (type & year, if any)

Any history of reaction to anesthesia?

Select

If yes, please describe

Family History

Family history of medical conditions (heart disease, diabetes, etc.)

Social History

Do you smoke?

Select

Do you consume alcohol?

Select

History of substance use?

Select

If yes, please describe

Additional Information

Any other concerns or information for your physician?

Patient/Guardian Signature

Date