

**CAROLINA SURGEONS**  
**Medical History Form**  
**(ALL INFORMATION IS STRICTLY CONFIDENTIAL)**

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for visit \_\_\_\_\_

Referring doctor \_\_\_\_\_ Regular medical doctor \_\_\_\_\_

List **ALL** medicines and dosages (including all over-the-counter medicines, herbals, supplements, and vitamins)  
(ALWAYS carry an up-to-date list of your medicines in your wallet)

\_\_\_\_\_  
\_\_\_\_\_

Do you take a blood thinner ? \_\_\_\_\_

List **ANY** and **ALL** allergies (including allergies to local or general anesthetics or tape)

\_\_\_\_\_  
Family History – major medical conditions (heart disease, stroke, diabetes, bleeding problems, or cancers)  
\_\_\_\_\_

**Past Medical History:** Have you ever had any of the following conditions?

- |  |    |     |       |
|--|----|-----|-------|
| High blood pressure (hypertension).....                  | No | Yes | _____ |
| Heart disease (angina, heart attack, valve problems)...  | No | Yes | _____ |
| CANCER of any kind .....                                 | No | Yes | _____ |
| Diabetes (requiring pills or insulin).....               | No | Yes | _____ |
| High cholesterol? When was it last checked?.....         | No | Yes | _____ |
| Epilepsy (seizures) Strokes or TIA's.....                | No | Yes | _____ |
| Lung Disease (asthma, bronchitis, emphysema, TB)...      | No | Yes | _____ |
| Kidney Disease (stones, infections, tumors).....         | No | Yes | _____ |
| Thyroid conditions.....                                  | No | Yes | _____ |
| Mental or Psychiatric problems (depression, neurosis)    | No | Yes | _____ |
| Skin conditions (skin cancer, psoriasis, skin ulcers)... | No | Yes | _____ |
| Stomach ulcers or reflux (GERD, heartburn).....          | No | Yes | _____ |
| Liver disease (cirrhosis, hepatitis, jaundice).....      | No | Yes | _____ |
| Any BLEEDING or clotting problems ("free-bleeder")       | No | Yes | _____ |
| Any significant recent weight gain or loss.....          | No | Yes | _____ |
| Do you have any hernias?.....                            | No | Yes | _____ |
| Have you had any exposure to AIDS (HIV)?.....            | No | Yes | _____ |
| ARE YOU PREGNANT?.....                                   | No | Yes | _____ |
| Do you have swollen or aching legs or leg ulcers?.....   | No | Yes | _____ |

List **ANY** and **ALL** surgical procedures with approximate dates \_\_\_\_\_  
\_\_\_\_\_

Do you smoke?? \_\_\_\_\_ How much? \_\_\_\_\_ Do you drink? \_\_\_\_\_ How much? \_\_\_\_\_

Do you use tobacco in any other form? (list) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

