Carolinas Center for Surgery

Medical History Form

Patients Full Name:	Date of Birth:
Preferred Pharmacy & Location:	Referring Dr:
Reason for Today's Visit:	
List All Allergies and Your Reaction:	
Date of Last Flu Shot:	Date of Pneumonia Vaccine:
Date of COVID Vaccine: History of COVID? ☐ Yes ☐ No	If yes, date of positive results:
List any Medical Conditions you are being treated for: (Diabetes, Heart Disease, High Blood Pressure, etc.)	
Height:	Weight:

List All Current Medications with Dosages and Frequency

Medication Name	Dosage (mg)	Frequency (times per day)

Please Turn Over

List all Previous Surgeries and Date of Surgery:

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Do you have any of the following devices: Cardiac Pacemaker, Implanted Cardiac Defibrillator, Stents, Neurostimulator, Spinal Cord Stimulator ☐Yes ☐No
If yes, please provide card/documentation of device to clinical staff

Have you had a Colonoscopy: ☐Yes ☐No Date of Colonoscopy: ____________ Normal? ______________

Family History

Please list any Cancer, Heart Disease, Diabetes, and Bleeding Disorders for the following family members:

Family Member
Mother:
Father:
Siblings:
Maternal Grandmother:
Maternal Grandfather:
Paternal Grandmother:
Paternal Grandfather:
Maternal Aunt:
Maternal Uncle:
Paternal Aunt:
Paternal Uncle:
Children:

Have you ever had a staph infection or MRSA? ☐Yes ☐No

Do you consume any type of nicotine? ☐Yes ☐No If Yes, what type? ____________________________

Date you quit nicotine consumption: __________________

Do you Drink Alcohol? ☐Yes ☐No # of Drinks per Day? _________ Social Drinker? ☐Yes ☐No

Have you ever or do you currently use Illicit Drugs? ☐Yes ☐No If yes, what type of drug(s): ____________

Have you had any problems with Anesthesia? ☐Yes ☐No Do you have a Latex Allergy? ☐Yes ☐No