CAPITAL SURGEONS GROUP, PLLC

PATIENT HEALTH INFORMATION

NAME OF PATIENT: ____________________ DATE OF BIRTH: __________ DATE: __________

REASON FOR VISIT: ____________________

PAST MEDICAL HISTORY

PREVIOUS SURGERIES		PREVIOUS HOSPITALIZATIONS	
TYPE:	DATE:	REASON:	DATE:
TYPE:	DATE:	REASON:	DATE:
TYPE:	DATE:	REASON:	DATE:
TYPE:	DATE:	REASON:	DATE:

MEDICAL ILLNESSES

	PATIENT		FAMILY		
	YES	NO	YES	NO	FAMILY MEMBER:
DIABETES	☐	☐	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	☐	☐	
HEART DISEASE	☐	☐	☐	☐	
KIDNEY DISEASE	☐	☐	☐	☐	
CANCER	☐	☐	☐	☐	

SPECIFY TYPE OF CANCER: ____________________

OTHER ILLNESSES: ____________________

CURRENT MEDICATIONS (Including HERBS, VITAMINS, SUPPLEMENTS & OVER-THE-COUNTER MEDICINE)

NAME:	DOSAGE:	NAME:	DOSAGE:
NAME:	DOSAGE:	NAME:	DOSAGE:
NAME:	DOSAGE:	NAME:	DOSAGE:
NAME:	DOSAGE:	NAME:	DOSAGE:

PREFERRED PHARMACY

PHARMACY NAME: ____________________

ADDRESS (or Cross Street/Intersection): ____________________

CITY: __________ PHONE: __________

DRUG & FOOD ALLERGIES		DRUG & FOOD ALLERGIES	
DRUG/FOOD:	REACTION:	DRUG/FOOD:	REACTION:
DRUG/FOOD:	REACTION:	DRUG/FOOD:	REACTION:
DRUG/FOOD:	REACTION:	DRUG/FOOD:	REACTION:

HABITS

Have you ever smoked tobacco? __________ If yes: How long / how much? __________ When did you quit? __________

How often do you consume alcohol? __________ How much caffeine do you consume? __________

Have you ever used IV street drugs? __________ How often do you exercise? __________

SOCIAL

☐ Married ☐ Divorced ☐ Single ☐ Widowed

Level of Education: ____________________ Occupation: ____________________

Patient Health Information
TRC/Revised 06/09/15
SAC/Effective 11/05/02

SIGNATURE DATE