SOUTH CAROLINA SURGICAL MEDICAL HISTORY FORM

DATE:_____________ **NAME:** ____

DOB: ___________ **AGE:** ______ **SSN:** ___________________________ **WT:** _______ **HT:**__________

REASON FOR VISIT: ____

PAST MEDICAL HISTORY:

- ❑ Diabetes/ Insulin or non insulin
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _______________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ CHF ❑ CAD ❑ cardiac stents

Other:___________________________

- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism/DVT
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Gout

PAST SURGICAL HISTORY:

____

Tobacco use: ___________________ Alcohol use: __________________ Street Drug use: ___________________

FAMILY MEDICAL HISTORY:

Father: ___________________________________ Brother: ________________________ Children: ___________

Mother: ___________________________________ Sister: _________________________

ALLERGIES: (list drug and **reaction):**

____

CURRENT MEDICATIONS: (**<u>If you have a list of your medications with you, please provide your list. If you have a list you do not need to write them down here</u>**. Please include over the counter medications.)

1 ___________________________________ 2____

3 ___________________________________ 4____

5 ___________________________________ 6____

7 ___________________________________ 8 ____

3/8/21 SC/JC

SOUTH CAROLINA SURGICAL PATIENT INFORMATION FORM

YOUR ADDRESS: ____

CITY: _____________________ **STATE:** _____________________ **ZIP CODE:** ___________

PHONE # ____________________________ **CELL PHONE #:** __________________________

EMAIL ADDRESS: ____

SIGNIFICANT OTHER/CAREGIVER/EMERGENCY CONTACT:

Name:_____________________________Phone #: ________________Relationship to you:_________

Name:_____________________________Phone #: ________________Relationship to you:_________

Do you have an advanced directive / Living will?: _______**Yes. Did you bring a copy with you?** ______
(This is about your health, not your money) _______ **No**

YOUR PRIMARY CARE PROVIDER: ____

Other providers/specialists:

Cardiology:____________________________ Nephrology: _______________________

Wound care:___________________________ Oncology: _________________________

Orthopaedics: _________________________ Ophthalmology: _____________________

GI: _________________________________ Gyn: _____________________________

Other: _______________________________

YOUR PHARMACY NAME: ____

ADDRESS_________________________________**PHONE NUMBER** ___________________________