SALEM GENERAL SURGERY
Initial Patient Questionnaire

Patient Name:____

Birth Date:__________________________ Age:________________

Form Completed By:____________________________ Date Completed:______________

MEDICAL HISTORY

Do you have a Latex allergy? ____ Yes _____ No

Are you a Diabetic? _____ Yes _____ No

Do you have any allergies to medication? ____ Yes _____ No
*If yes, please list the medication and your reaction:

____
____
____

Do you consider yourself to be in good health? _____ Yes _____ No
*If no, please explain:

____
____
____

Please list your medical problems:

____
____
____
____
____
____
____

Please list all medications, including dosage and instructions, you are currently taking, including over-the-counter medicines, herbal supplements and vitamins:

____
____
____
____
____
____

Please list your past hospitalizations, the year and the reason for the hospitalization:

____
____
____
____
____

Please list any past surgeries you have had:

____
____
____
____
____

FAMILY HISTORY

	Relationship		Relationship
___ Anemia	______	___ Breast Cancer	______
___ Alcohol abuse	______	___ Cervical Cancer	______
___ Tuberculosis	______	___ Colon/Rectal Cancer	______
___ Diabetes (before 50 years old)	______	___ Ovarian Cancer	______
___ Heart disease (before 50 years)	______	___ Prostate Cancer	______
___ High cholesterol	______	___ Uterine Cancer	______
___ Kidney disease	______	___ Inflammatory Bowel Disease	______
___ Liver disease	______	___ Crohn's Disease	______
___ Mental illness	______	___ Ulcerative Colitis	______

Explanations or additional family history:

____
____
____
____
____
____

SOCIAL HISTORY

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Please list your children's names, ages and gender, if you have any:

Name	Age	Male or Female

Your Occupation & Place of Employement:______________________________

How often do you drink alcoholic beverages?

_____ Never
_____ Rarely
_____ Weekly (amount____________________)
_____ Daily (amount____________________)

Do you smoke?

_____ No
_____ Yes (amount____________________)

Did you used to smoke?

_____ No
_____ Yes (amount________________age started smoking__________age quit_______)

Do you or have you ever used recreational drugs?

_____ No
_____ Yes (please explain:____)