Surgical Care Specialists

A Full Service Surgical Practice

Abington Hospital Office Building
1245 Highland Avenue, Suite 600
Abington, Pennsylvania 19001
215-887-3990 Fax: 215-887-1140

PATIENTS NAME: ______________________ DATE: ______________

PATIENT HISTORY

BIRTH DATE: HEIGHT: WEIGHT:

PLEASE LIST MEDICAL PROBLEMS FOR WHICH YOU HAVE BEEN TREATED BY A PHYSICIAN (I.E. HYPERTENSION, HEART DISEASE, DIABETES, ETC.)

PLEASE LIST PREVIOUS HOSPITALIZATIONS:

PLEASE LIST PREVIOUS SURGERIES:

PLEASE LIST YOUR FAMILY PHYSICIAN:

PLEASE LIST YOUR REFERRING PHYSICIAN:

PLEASE LIST ALL PHYSICIANS WHO HAVE TREATED YOU IN THE PAST THREE YEARS:

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING AT THIS TIME:

PLEASE LIST ALL VITAMINS, OVER THE COUNTER MEDICATIONS, & NATURAL HERBS YOU TAKE:

IF YOU ARE ALLERGIC TO ANY DRUGS / MEDICATIONS, PLEASE LIST THESE:

DO YOU SMOKE CIGARETTES? ❑ YES ❑ NO | HAVE YOU PREVIOUSLY? ❑ YES ❑ NO | IF YOU SMOKE, HOW MANY PACKS PER DAY? ________

DO YOU DRINK ALCOHOLIC BEVERAGES? ❑ YES ❑ NO | IF YES PLEASE CHECK THE BEST DESCRIPTION ❑ RARELY ❑ OCCASIONALLY ❑ DAILY

HAVE YOU OR ANY RELATIVES BEEN TREATED FOR MEDICAL CONDITIONS SUCH AS CANCER, HEART DISEASE, DIABETES, THYROID CONDITIONS, HYPERTENSION, DIVERTICULITIS, OR GALLBLADDER DISEASE? ❑ YES ❑ NO

IF YES, PLEASE EXPLAIN BELOW:

ANY ADDITIONAL INFORMATION COMMENTS/REGARDING YOUR MEDICAL HISTORY OR CONDITION MAY BE LISTED HERE:

THANK YOU FOR YOUR HELP IN PROVIDING ACCURATE INFORMATION

REV. 3/04