COLLIN COUNTY SURGEONS
Medical History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Current Medications	Dosage

Previous Surgery	Date

Are you allergic to any medications? Yes or No (If yes, please list.)

Drug	Reaction

Have you ever had any of the following? Circle all that apply: High Blood Pressure, Diabetes, Heart problems, Irregular heartbeat, Heart failure, Pneumonia, Chronic cough, History of Stroke, Headaches, Heartburn, Bowel disorders, IBS, Constipation, Diarrhea, Hemorrhoids, Hepatitis, Rectal bleeding, Kidney disease, Kidney stones, Bladder problems, Prostate, Incontinence of urine, Blood in urine, Thyroid disease, Lung disease, Asthma, COPD, Jaundice, Liver, Gout, Breast cancer, Leukemia/Lymphoma, Tuberculosis, Psychiatric Disorder, Depression, Anxiety, Alcoholism, Anemia, Transfusions, Immune disease or HIV, Skin Disease, Joint Disease, Epilepsy-Seizures, Blood Clot ,

Do you smoke? Yes No or Never If yes, how many packs per day? _____

Do you use alcohol? Yes No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months? Marijuana Cocaine Heroin Crack Methamphetamine

Family History (Please circle)
Mother: Alive / Deceased Father: Alive / Deceased

Is there any history of the following medical conditions in your family? Please circle.

Heart disease Lung disease Bowel disease Kidney disease Diabetes Hypertension Cancer

Date of last Flu shot:_____
Date of last pneumococcal shot:_____

Primary Care Physician:_____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____