SUFFOLK SURGICAL ASSOCIATES, PC

Patient Medical Information Sheet:

Please answer the following questions. If answer is NONE, please indicate.

*PATIENT NAME:*_____*DATE:*_____

- REASON FOR THIS APPOINTMENT:_____
- DATE OF ONSET OF ILLNESS OR INJURY:_____
- INJURY OCCURRED AT:_____
- PRIOR MEDICAL PROBLEMS:_____
  _____
  _____
- PRIOR SURGERY: _____
  _____
- PROBLEMS WITH PRIOR SURGERIES:_____
  _____
- PRIOR HOSPITALIZATIONS:_____
  _____
- SIGNIFICANT FAMILY ILLNESS:_____
  _____
- MEDICATIONS:_____
- ALLERGIES TO MEDICATIONS:_____
- DO YOU TAKE
  ASPIRIN, MOTRIN, ECOTRIN, ALEVE, IBUPROFEN:_____
- DO YOU TAKE ANY
  HERBAL REMEDIES:_____
- SMOKING HABITS:_____
- DRINKING HABITS:_____
- PRIMARY CARE PHYSICIAN:_____

OFFICE M.D. SIGNATURE:_____DATE:_____