NEWTON WELLESLEY SURGEONS, INC.

TODAYS DATE: _____

NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR: _____

REASON FOR VISIT: _____

MEDICAL HISTORY:

Medical Problem ***Year Diagnosed*** ***Physician***

1._____
2._____
3._____
4._____
5._____

SURGICAL HISTORY:

Operation or Hospitalization ***Year*** ***Hospital*** ***Physician***

1._____
2._____
3._____
4._____
5._____

CURRENT MEDICATIONS:

Name ***Dosage***

1._____
2._____
3._____
4._____
5._____

ALLERGIES:

1._____
2._____
3._____
4._____

HEIGTH: _____ft _____in WEIGHT: _____1bs

DO YOU SMOKE? ☐ **YES** ☐ **NO** IF YES HOW MUCH:_____

DO YOU DRINK ALCOHOL? IF YES HOW MUCH:_____

OCCUPATION: _____

FAMILY HISTORY OF CANCER:

WHO: _____ TYPE:_____

WHO: _____ TYPE:_____