NEWTON WELLESLEY SURGEONS, INC.

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: _____lbs

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:_____

PLEASE COMPLETE REVERSE SIDE