Frederick T. Sutter, MD, LLC
Center for Wellness Medicine

# Medication & Surgical History Form

Date: _____

Patient Name:_____ Date of Birth: _____

## Allergies

| Name of Substance (drug or food) | Type of Reaction |
|---|---|
| □ Check if none | |
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Do you react to latex or rubber (gloves, balloons, etc.) with a rash, wheezing, etc.? □ Yes □ No

## Current Medications

| Prescription Drugs (such as Atenolol, eye drops, ointments) | Strength (5 mg, etc) | Directions (such as 1 tablet twice a day) Check box if taken only as needed. | | Name of the provider who prescribed the medication |
|---|---|---|---|---|
| □ Check if none | | | | |
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| Over-the-Counter Medications (such as ibuprofen) | Strength | Directions (such as "take as needed for pain") |
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| Herbs, Vitamins, Minerals, Etc. (such as Glucosamine) | Strength | Directions (such as one tablet per day) |
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Patient Name:_____ Date of Birth:_____

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| Type Of Surgery | Approximate Date | Surgeon / Hospital |
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## Social History

***Tobacco Use***

Do you smoke or use any tobacco products?…… ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day? _____

For how many years? _____

Year that you quit? _____

Other forms of tobacco used? _____

***Alcohol Use***

Do you drink alcohol?…… ☐ Yes ☐ No ☐ Quit

Type of Alcohol? ☐ Beer ☐ Wine ☐ Hard Liquor

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking?…….. ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? …… ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking? …… ☐ Yes ☐ No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No