



**LONGMONT
SURGERY
CENTER, LLC**

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PATIENT HISTORY FORM

ALLERGIES: _____

DAILY MEDICATIONS (Please include non-prescription & supplements): _____

SURGERIES: _____

Lung Disease: yes no
(Eg: emphysema, COPD, asthma)

Diabetes yes no

Kidney disease: yes no

High B/P: yes no

Heart disease: yes no
(Eg: Irreg. Heart beat, pacemaker, angina, etc.)

HIV: yes no

Hepatitis: yes no

Neurological: yes no

Stomach/intestinal: yes no

Arthritis: yes no

Other: _____

For any yes answers please explain: _____

Patient Signature: _____

Reviewed by: _____