The Surgical Center of Midland
Medical History

Patient Name: ___________________________________

The following information regarding your medical history is needed in order to schedule your surgery.

1. What pharmacy do you use?

____

City: ________________________________

Street: _______________________________

2. What Insurance do you use for prescriptions? ________________________

3. HEIGHT: ______________

WEIGHT: ______________

4. Please check any medical conditions that apply to you:

		Additional Information
❑	No known medical conditions	
❑	Asthma	
❑	Arthritis	
❑	Bleeding Disorder	
❑	Cancer	
❑	Diabetes	
❑	Heart Attack	
❑	Hepatitis	
❑	High Cholesterol	
❑	HIV	
❑	Hypertension	
❑	Liver Disease	
❑	Lung Disease	
❑	MRSA	
❑	Stroke	
❑	Thyroid Disorder	
❑	Tuberculosis	
❑	Other	

4. Please list below, or provide a list of the medications that you are currently taking.

❑ **Not currently taking Medication**

❑ **Currently taking the following medication:**

____
____
____
____
____
____
____

5. Are you allergic to any medication, foods, or chemicals? ___________________

If yes, please list:

____
____
____

6. Have you had any major surgery? ____

If yes, please list and provide the year:

____
____
____
____

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Medical History

Patient Name: ___________________________________

The following information regarding your medical history is needed in order to schedule your surgery.

7. MEN ONLY:
Have you ever taken any prostate medications such as FLOMAX, JALYN, or TAMSULOSIN? ___________________
If yes, in what year? ___________________
For how long? ________________________