PALO ALTO
SURGERY CENTER

Patient's Name_____
Last Name First Name Middle Initial

Street Address_____

City_____ State, Zip_____

Home Phone_____ Work/Cell Phone_____

Occupation_____ Emergency Contact/Phone_____

Date of Birth _____ Age _____ Sex M F

EMAIL _____

Preferred Pharmacy Name/Phone _____ SSN*** _____

Have you ever had any of the following medical conditions? When? Treatment?
Please explain all yes answers

Any serious medical problems ☐yes ☐no _____

Current medications, Prescription OR over the counter (Please list frequency, dosage, and reason for taking.) ☐yes ☐no _____
_____

Any allergies (Please list) ☐yes ☐no _____
_____

Heart problems ☐yes ☐no _____
Bleeding problems ☐yes ☐no _____
Lung problems ☐yes ☐no _____
Diabetes (Specify Type) ☐yes ☐no _____
Herpes (Specify Type) ☐yes ☐no _____
Seizures, epilepsy, fainting ☐yes ☐no _____
Neurological diseases such as a
Multiple Sclerosis or Myasthenia ☐yes ☐no _____
Gravis ☐yes ☐no _____
Neuromuscular problems ☐yes ☐no _____
Aids ☐yes ☐no _____
Hepatitis (Specify Type) ☐yes ☐no _____
Are You Pregnant or Nursing ☐yes ☐no _____
Lupus ☐yes ☐no _____
Autoimmune diseases ☐yes ☐no _____

SIGNATURE OF PATIENT _____DATE_____