Surgical History Update Form

Dear [Patient's Name],

Welcome to our practice! As part of your initial evaluation, we would like to gather detailed information regarding your surgical history. Please take a moment to fill out the following sections:

Basic Information

Full Name: ___________________________

Date of Birth: _______________________

Contact Number: _____________________

Surgical History

1. Have you had any previous surgeries? (Yes/No) ___________________

If yes, please list all surgeries and the dates:

- ___________________________ - Date: _______________
- ___________________________ - Date: _______________
- ___________________________ - Date: _______________

Current Medications

Please list any medications you are currently taking:

- ___________________________
- ___________________________
- ___________________________

Allergies

Do you have any known allergies? (Yes/No) ___________________

If yes, please specify:

- ___________________________
- ___________________________

Thank you for providing this important information. Please return this form at your earliest convenience. We look forward to assisting you!

Sincerely,
[Your Healthcare Provider's Name]
[Your Practice Name]