# Surgical History Update for Pre-Operative Assessment

Date: _____

Patient Name: _____

Date of Birth: _____

Patient ID: _____

## Previous Surgeries:

- Surgery: _____ | Date: _____ | Surgeon: _____
- Surgery: _____ | Date: _____ | Surgeon: _____
- Surgery: _____ | Date: _____ | Surgeon: _____

## Current Medications:

- Medication: _____ | Dosage: _____
- Medication: _____ | Dosage: _____

## Allergies:

- Allergen: _____ | Reaction: _____
- Allergen: _____ | Reaction: _____

## Recent Medical Conditions:

- Condition: _____ | Date Diagnosed: _____
- Condition: _____ | Date Diagnosed: _____

## Additional Notes:

_____

_____

Physician Signature: _____

Physician Name: _____ | Contact Number: _____