USGH Hospital

Doctor's Report

Patient's Name: _____ **Initial Diagnosis:** _____

DOB: _____ **Date:** _____

Does the issue require surgery?

☐ No

☐ Yes If Yes, Date of Surgery: _____

Medical History: Do you have a history of the following problems?

☐	Asthma	☐	Electrical implants
☐	Diabetes	☐	Anxiety attacks
☐	Heart Problems	☐	Sleep apnea
☐	Cancer	☐	Depression
☐	Stroke	☐	Bowel problems
☐	Bone/ joint problems	☐	Alcohol abuse
☐	Kidney problems	☐	Drug use
☐	Gallbladder	☐	Smoking
☐	Liver problems	☐	Headaches

Past Surgeries:

☐ No surgeries

Hospital:		**Year:**		**Complications:**	
Hospital:		Year:		Complications:	
Hospital:		Year:		Complications:	

Allergies:
(list down allergies you have)

_____

_____

_____

Medications
(and dosage):

☐ No medications

_____

_____

Additional Notes:

_____

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