

# RUSSELL B. STOKES, MD

A Medical Corporation

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## Personal Surgery History

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**Please list any surgeries you have had in the past**

1. \_\_\_\_\_ Date \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Date \_\_\_\_\_
4. \_\_\_\_\_ Date \_\_\_\_\_

Did you have any complications with any of the surgeries? \_\_\_\_\_  
\_\_\_\_\_

Do any medical problems run in your family? \_\_\_\_\_

**Please list any medications you are currently taking**

1. \_\_\_\_\_ Dosage \_\_\_\_\_
2. \_\_\_\_\_ Dosage \_\_\_\_\_
3. \_\_\_\_\_ Dosage \_\_\_\_\_
4. \_\_\_\_\_ Dosage \_\_\_\_\_
5. \_\_\_\_\_ Dosage \_\_\_\_\_

Are you currently taking any aspirin or other anti-inflammatory medication? \_\_\_\_\_

Are you currently taking any diet drugs or herbal supplements? \_\_\_\_\_

Thank you for taking the time to accurately fill out this questionnaire. By signing below, you are certifying that this information is accurate the best of your knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_