



PATIENT NAME: _____ DATE: _____

PAST MEDICAL HISTORY

Age: _____ Height: _____ Weight: _____ Reason for Visit? _____

MEDICATIONS:	Name	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Have you had any of the following?
Please check appropriate boxes.**

Past Medical History

- ☐ High Blood Pressure
- ☐ Acute Myocardial Infarction
- ☐ A-Fib
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Venous Thrombosis (DVT)
- ☐ Cancer Type: _____
- ☐ High Cholesterol
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder Type: _____
- ☐ Esophageal Reflux
- ☐ Seizure Disorder
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ Renal Failure
- ☐ Blood Disorder Type: _____
- ☐ HIV Infection
- ☐ Hepatitis
- ☐ Other _____

Referring Provider:

Address: _____

Phone: () _____

Family Doctor: _____

Phone: () _____

Cardiologist: _____

Phone: () _____

Other: _____

Phone: () _____

Do you have a **pacemaker**? Yes No

Are you presently on **dialysis**? Yes No

Do you have a **cardiac stent**? Yes No



DATE:

Please list any allergies including those to drugs, latex, adhesive tape, food, etc. and include your reaction:

Name of Surgery

[illegible]

Reason (no surgeries, please)

[illegible]



Name: _____ DOB: _____ Date: _____

FAMILY HISTORY:

	Alive	Deceased	Unknown
Father	☐	☐	☐
Mother	☐	☐	☐
Paternal Grandfather	☐	☐	☐
Paternal Grandmother	☐	☐	☐
Maternal Grandfather	☐	☐	☐
Maternal Grandmother	☐	☐	☐
Brothers	☐	☐	☐
Sisters	☐	☐	☐
Children	☐	☐	☐

Present Illness / Cause of Death

(please include age at diagnosis of breast and colon cancers, if possible)

Social History

Current Smoker: ☐ Y ☐ N
Packs per day? _____ No. of years? _____
Former Smoker: ☐ Y ☐ N
Year you quit: _____

Other Tobacco Use? ☐ Y ☐ N
Type? _____

Alcohol Use: ☐ Y ☐ N
Frequency? _____

Recreational Drug Use: ☐ Y ☐ N
Type/frequency? _____

Women Only:

Age at first period: _____
Number of pregnancies: _____
Number of children: _____
Date of last period: _____
Age at first birth: _____
Age at menopause: _____
Number of previous breast biopsies: _____
Family history of breast/ovarian cancer: Yes No
History of hormone replacement use: Yes No
Length of time taken: _____ Therapy: Yes No
History of birth control use: Yes No
Length of time taken: _____

Name: _____ Date of Birth: _____

Do you currently have any of the following?

General Symptoms

- ☐ Y ☐ N Weight Change
If yes, indicate gained or lost? _____
Amount? _____
- ☐ Y ☐ N Increase in Appetite
- ☐ Y ☐ N Decrease in Appetite
- ☐ Y ☐ N Fever
- ☐ Y ☐ N Chills
- ☐ Y ☐ N Tiring Easily

Skin Symptoms

- ☐ Y ☐ N Itching
- ☐ Y ☐ N Skin Lesions
- ☐ Y ☐ N Rashes
- ☐ Y Other: _____

Head Symptoms

- ☐ Y ☐ N Headache
- ☐ Y ☐ N Corrective Lenses
- ☐ Y Other: _____

Neck Symptoms

- ☐ Y ☐ N Neck Pain
- ☐ Y ☐ N Neck Stiffness
- ☐ Y ☐ N Lump or Swelling
- ☐ Y Other: _____

Otolaryngeal Symptoms

- ☐ Y ☐ N Earache
- ☐ Y ☐ N Hearing Loss
- ☐ Y ☐ N Nosebleeds
- ☐ Y ☐ N Mouth Sores
- ☐ Y ☐ N Bleeding Gums
- ☐ Y ☐ N Hoarseness
- ☐ Y ☐ N Throat Pain
- ☐ Y Other: _____

Cardiovascular

- ☐ Y ☐ N Chest Pain or Discomfort
- ☐ Y ☐ N Fast Heart Rate
- ☐ Y ☐ N Palpitations
- ☐ Y Other: _____

Pulmonary Symptoms

- ☐ Y ☐ N Wheezing (Asthma)
- ☐ Y Other: _____

Endocrine Symptoms

- ☐ Y ☐ N Excessive Sweating
- ☐ Y ☐ N Excessive Thirst
- ☐ Y Other: _____

Hematologic Symptoms

- ☐ Y ☐ N Easy Bleeding
- ☐ Y ☐ N Easy Bruising Tendency
- ☐ Y Other: _____

Gastrointestinal Symptoms

- ☐ Y ☐ N Difficulty Swallowing
- ☐ Y ☐ N Heartburn
- ☐ Y ☐ N Ulcer
- ☐ Y ☐ N Nausea
- ☐ Y ☐ N Vomiting
- ☐ Y ☐ N Abdominal Pain
- ☐ Y ☐ N Bowel/Bladder Changes
- ☐ Y ☐ N Diarrhea
- ☐ Y ☐ N Constipation
- ☐ Y ☐ N Black or Tarry Stools
- ☐ Y ☐ N Rectal Bleeding
- ☐ Y Other: _____

Genitourinary Symptoms

- ☐ Y ☐ N Pain During Urination
- ☐ Y ☐ N Increased Urinary Frequency
- ☐ Y ☐ N Blood in Urine
- ☐ Y ☐ N Genital Lesion
- ☐ Y Other: _____



Do you currently have any of the following?

Musculoskeletal Symptoms

- ☐ Y ☐ N Joint Pain
☐ Y ☐ N Joint Stiffness
☐ Y ☐ N Muscle Aches
☐ Y Other: _____

Psychological Symptoms

- ☐ Y ☐ N Sleep Disturbances
☐ Y ☐ N Anxiety
☐ Y ☐ N Depression
☐ Y Other: _____

Neurological Symptoms

- ☐ Y ☐ N Dizziness
☐ Y ☐ N Vertigo
☐ Y ☐ N Fainting
☐ Y ☐ N Motor Disturbances
☐ Y ☐ N Sensory Disturbances
☐ Y Other: _____

Screening and Immunization History

(All patients)

Did you receive a flu vaccination during last year's flu season (October - March)? ☐ Y ☐ N

Approximate Date _____

*Surgical Specialists' physicians recommend you obtain an annual flu vaccine.

(All patients ages 50-75)

When was your last colonoscopy? _____

*Surgical Specialists' physicians recommend you have a screening colonoscopy every 10 years unless otherwise indicated by your family doctor or specialist.

(Female patients age 40 or older)

When was your last mammogram? _____

*Surgical Specialists' physicians recommend you have a yearly screening mammogram.

(All patients age 65 or older)

Have you ever received a pneumonia vaccination?

☐ Y ☐ N Approximate Date _____

*Surgical Specialists' physicians recommend you receive a pneumonia vaccine if you are age 65 or older and have not yet received one.

I VERIFY THAT THE INFORMATION ON THIS QUESTIONNAIRE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____