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**General Surgery**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_  
 Family/Referring Physician(s): \_\_\_\_\_ Pharmacy (name & location): \_\_\_\_\_

**Chief Complaint** (What medical problem brings you in today): \_\_\_\_\_  
 § When did it start? \_\_\_\_\_  
 § What medications/treatments have you tried? \_\_\_\_\_  
 § What tests/Xrays have you had for this? (Where?) \_\_\_\_\_

**Personal Medical History** (Check all that apply and fill in where appropriate)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Seizures Type: _____<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Glasses/Contacts<br><input type="checkbox"/> Hearing Aids<br><input type="checkbox"/> Dentures<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Chronic Bronchitis/ Emphysema/<br>COPD<br><input type="checkbox"/> Sleep Apnea<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Abnormal Chest Xray<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Abnormal Heart Rhythm<br><input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Anemia/ Low Blood Count<br><input type="checkbox"/> Blood Clot<br><input type="checkbox"/> Bleeding Disorder<br><input type="checkbox"/> Leg Swelling<br><input type="checkbox"/> Aneurysm<br><input type="checkbox"/> Abnormal Liver Test<br><input type="checkbox"/> Hepatitis Type: _____<br><input type="checkbox"/> Cirrhosis<br><input type="checkbox"/> Reflux/ Heartburn<br><input type="checkbox"/> Stomach Ulcer<br><input type="checkbox"/> Irritable Bowel Syndrome<br><input type="checkbox"/> Ulcerative Colitis/ Crohn's<br>Disease | <input type="checkbox"/> Colon Polyps<br><input type="checkbox"/> Kidney Failure<br><input type="checkbox"/> Kidney Stones<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Artificial joint (prosthetic, pins,<br>rods)<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Cancer Type: _____<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Radiation Therapy<br>Other: _____<br>_____<br>_____<br>_____ |
|---|--|---|

**Surgery/ Procedures** (List all procedures or operations you have had)  None

Surgery/ Procedure	Date	Why?

**Medications** (List ALL medications you take, including over-the-counter and herbal supplements)  See Attached List  None

Name	Dose	How often?	What For?

(TURN OVER)

**Allergies**

Are You Allergic to any **Medications**?  **Yes**  **No** (Please List) \_\_\_\_\_  
Are You Allergic to **Latex**?  **Yes**  **No**      **Tape**?  **Yes**  **No**      **Iodine/Dye**?  **Yes**  **No**

**Review of Systems** (Do you **CURRENTLY** have a problem with any of the following?)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fever                            | <input type="checkbox"/> Wheezing              | <input type="checkbox"/> Urination             |
| <input type="checkbox"/> Night Sweats                     | <input type="checkbox"/> Snoring               | <input type="checkbox"/> Kidneys               |
| <input type="checkbox"/> Lethargy                         | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Pregnancy             |
| <input type="checkbox"/> Unexplained Weight Gain _____lbs | <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Last Period: _____    |
| <input type="checkbox"/> Unexplained Weight Loss _____lbs | <input type="checkbox"/> Circulation           | <input type="checkbox"/> Breast                |
| <input type="checkbox"/> Loss of Appetite                 | <input type="checkbox"/> Bleeding              | <input type="checkbox"/> Trouble Walking       |
| <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Weakness in Arms/Legs |
| <input type="checkbox"/> Headache                         | <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Numbness/Tingling     |
| <input type="checkbox"/> Change in Vision                 | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Joint pain            |
| <input type="checkbox"/> Hearing                          | <input type="checkbox"/> Bloating              | <input type="checkbox"/> Swelling              |
| <input type="checkbox"/> Sinuses                          | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Infection             |
| <input type="checkbox"/> Nose Bleeds                      | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Anxiety               |
| <input type="checkbox"/> Chronic Cough                    | <input type="checkbox"/> Bloody Stool          | <input type="checkbox"/> Sadness               |
| <input type="checkbox"/> Shortness of Breath              | <input type="checkbox"/> Change in Stool       | <input type="checkbox"/> Fear                  |

Please explain any problems noted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History**

Marital Status:            Single   Married            Separated            Divorced            Widowed  
Occupation: \_\_\_\_\_  
Use of Alcohol:            Never            Rarely            Moderate            Daily    Drinks per day: \_\_\_\_\_  
Use of Tobacco:            Never            Previously, but quit    When? \_\_\_\_\_    Current Packs/Day: \_\_\_\_\_  
Use of Drugs:            Never            Yes            Type/Frequency: \_\_\_\_\_

**Family History** (Has anyone in your immediate family (mother, father, sister, brother, grandparents) had any of the following)  
(Please list relation and age)

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol or drug problem: _____   | <input type="checkbox"/> Stroke: _____                                       |
| <input type="checkbox"/> Bowel Problems, explain: _____   | <input type="checkbox"/> Endocrine Disease (i.e. Thyroid or Pancreas): _____ |
| <input type="checkbox"/> Breast Cancer: _____             | <input type="checkbox"/> Obesity: _____                                      |
| <input type="checkbox"/> Colon Cancer: _____              | <input type="checkbox"/> Symptoms like you have today? Explain: _____        |
| <input type="checkbox"/> Ovarian or Uterine Cancer: _____ | _____  |
| <input type="checkbox"/> Diabetes: _____                  | _____  |
| <input type="checkbox"/> Heart Disease: _____             |  |

**Additional Information** Is there anything else, not already addressed, that you think we should know to provide you better, more complete medical care?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nurse Use Only	
<b>T:</b> _____	<b>BMI:</b> _____
<b>P:</b> _____	<b>Notes</b>
<b>BP:</b> _____	_____
<b>R:</b> _____	_____
<b>Wt:</b> _____	_____
<b>Ht:</b> _____	_____

**The above information is true and correct. Any false or omitted information may hinder my care.**

\_\_\_\_\_  
**Clinic Staff Signature**

\_\_\_\_\_  
**Patient's Signature**