GENERAL SURGERY ASSOCIATES

Medication List as of _____(DATE)

Name _____ Birthday_____

Home Phone _____ Cell Phone _____

Pharmacy _____Pharmacy Phone _____

Medication	Dosage	Quantity	Frequency

Drug Allergies	Describe Reactions to Drug

PATIENT HEALTH HISTORY

Patient Name_____ Birthday_____ Sex _____

Referring Physician_____ Today's Date _____

Have you been diagnosed with? (Circle Yes or No)

High Blood Pressure	Y	N	Sleep Apnea	Y	N	Gallbladder Trouble	Y	N
Heart Murmur	Y	N	Diabetes	Y	N	Ulcers	Y	N
Heart Attack	Y	N	Sickle Cell Disease	Y	N	Colitis/Diverticulitis	Y	N
Irregular Heartbeat	Y	N	Asthma	Y	N	Stroke	Y	N
Rheumatic Fever	Y	N	Pneumonia	Y	N	Thyroid Disease	Y	N
Varicose Veins	Y	N	Emphysema/COPD	Y	N	Arthritis	Y	N
Anemia	Y	N	Jaundice (eye yellow)	Y	N	C-Sections	Y	N
Bleeding Problems	Y	N	Liver Disease	Y	N	Kidney Problems	Y	N

CANCER: **What Type** _____ **When** _____

Radiation Treatment _____

Have you been experiencing following conditions within last 3 months (check all that apply):

Constitutional: ☐Fever ☐Chill ☐Weight Loss (unintentional) ☐Excessive Fatigue

Eyes: ☐Double Vision ☐Eye Pain ☐Glaucoma

ENT: ☐Hearing Problems ☐Ringing in Ears ☐Dentures ☐Hoarseness

Cardiac: ☐Chest Pain ☐Palpitations ☐Shortness of Breath

Respiratory: ☐Cough ☐Coughing-up Blood ☐Wheezing ☐Asthma ☐Sleep Apnea ☐Shortness of Breath

GI: ☐Diarrhea ☐Black Stools ☐Constipation ☐Blood in Stool ☐Heartburn

GU: ☐Burning when Urinating ☐Blood in Urine ☐Frequent Urination ☐Prostate Problems ☐History of Urinary Tract Infections

Musculoskeletal: ☐Calf Pain ☐Weakness ☐Joint Pain ☐Joint Swelling ☐Leg Swelling

Neurologic: ☐Fainting/Blackouts ☐Seizures

Hematological: ☐Hepatitis ☐Easy Bruising ☐Clotting Disorder ☐Excessive Bleeding ☐Previous Transfusion ☐Lymph Node Swelling

Endocrine: ☐Heat/Cold Intolerance ☐Excessive Sweating

Immunologic/ID: ☐Tuberculosis ☐Immunosupression ☐HIV

Psychiatric: ☐Anxiety ☐Depression ☐Suicidal Thoughts

Breast: ☐Breast Mass ☐Breast Skin Changes ☐Breast Tenderness ☐Nipple discharge

SOCIAL HISTORY

Tobacco Use: Current Smoker_____ Past Smoker_____ Year Stopped_____

How many packs per day? _____ How many years? _____

Alcohol Use: How much per day? _____

Use of street drugs (past or present): Yes No

Have you ever been diagnosed with:

Hepatitis (Please Circle Type) Yes Type: A B C No HIV Virus: Yes No

Are you Taking Blood Thinners (Aspirin, Plavix, Coumadin, Jantoven, Warfarin, Heparin, Xareltro, etc**:**

Yes No

NAME_____BIRTHDAY_____

SURGERY HISTORY

Please list all surgical procedures

Type	Date	Location	Surgeon

FAMILY HISTORY

	Age (if living)	Health Good/Bad	Cancer?	Heart Disease?	High Blood Pressure	Age of Death	Cause
Mother							
Father							
Brothers							
Sisters							

Marital Status: Single_____ Married _____ Widowed _____ Divorced _____

Number of Children _____

Do you live alone? Yes _____ No _____

_____

_____

_____

_____

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