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General Surgery
Thoracic Surgery
Vascular Surgery
Laparoscopic Surgery
Gastrointestinal Endoscopy
Oncological Surgery

Diplomates of the American Board of Surgery

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PATIENT INFORMATION:

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____

PLACE OF EMPLOYMENT: _____

OCCUPATION: _____

WORK PHONE: _____

NAME OF PHYSICIAN WHO REFERRED YOU: _____

NAME OF YOUR PRIMARY CARE PHYSICIAN: _____

IS THIS ILLNESS OR INJURY JOB RELATED?: _____

IF JOB RELATED, WHAT WAS YOUR DATE OF ACCIDENT OR INJURY? _____

IS THERE ANY LEGAL ACTION PENDING?: _____

WHAT PROBLEM BRINGS YOU TO THE OFFICE?: _____

HOW LONG HAVE YOU HAD THIS PROBLEM?: _____

HAVE YOU BEEN TREATED FOR THIS PROBLEM BEFORE?: _____

IF YES, WHO HAS SEEN YOU FOR THIS PROBLEM?: _____

PATIENT'S SPOUSE / PARENT INFORMATION:

NAME: _____ BIRTHDATE: _____

SOCIAL SECURITY #: _____

PLACE OF EMPLOYMENT: _____

OCCUPATION: _____

WORK PHONE: _____

PLEASE LIST ALL PAST AND PRESENT MEDICAL HISTORY:

PLEASE LIST ALL MEDICATIONS:

PLEASE LIST ALL OPERATIONS:

DO YOU HAVE ANY ALLERGIES TO MEDICATION? IF SO, PLEASE LIST:

DO YOU SMOKE? IF YES, PLEASE LIST HOW MUCH:

DO YOU DRINK ALCOHOL DAILY? _____

DO YOU USE DRUGS? _____

SYSTEM REVIEW

| | | |
|---------------------|-----|----|
| GOOD GENERAL HEALTH | YES | NO |
| FATIGUE | YES | NO |

EYES

| | | |
|--------------------------|-----|----|
| BLURRED OR DOUBLE VISION | YES | NO |
| GLAUCOMA | YES | NO |
| GLASSES OR CONTACTS | YES | NO |
| CATARACTS | YES | NO |

EARS, NOSE, MOUTH, THROAT

| | | |
|-------------------------|-----|----|
| HEARING LOSS OR RINGING | YES | NO |
| EARACHES | YES | NO |
| CHRONIC SINUS PROBLEMS | YES | NO |
| NOSE BLEEDS | YES | NO |
| SORE THROAT | YES | NO |
| MOUTH SORES | YES | NO |
| GLANDS | YES | NO |

GASTROINTESTINAL

| | | |
|----------------|-----|----|
| HEARTBURN | YES | NO |
| DIARRHEA | YES | NO |
| CONSTIPATION | YES | NO |
| BLOOD IN STOOL | YES | NO |

INTEGUMENTARY (SKIN)

| | | |
|---------------------|-----|----|
| RASH OR ITCHING | YES | NO |
| EASY BRUISING | YES | NO |
| CHANGE IN ANY MOLES | YES | NO |

MUSCULOSKELETAL

| | | |
|------------------|-----|----|
| JOINT PAIN | YES | NO |
| JOINT STIFFNESS | YES | NO |
| SWELLING IN LEGS | YES | NO |
| WEAKNESS | YES | NO |
| BACK PAIN | YES | NO |
| OSTEOARTHRITIS | YES | NO |

NEUROLOGICAL

| | | |
|-----------|-----|----|
| HEADACHES | YES | NO |
| DIZZINESS | YES | NO |

CARDIOVASCULAR

| | | |
|----------------|-----|----|
| CHEST PAIN | YES | NO |
| VARICOSE VEINS | YES | NO |
| PACEMAKER | YES | NO |

RESPIRATORY

| | | |
|---------------------|-----|----|
| CHRONIC COUGHS | YES | NO |
| SPITTING UP BLOOD | YES | NO |
| SHORTNESS OF BREATH | YES | NO |
| ASTHMA | YES | NO |
| EMPHYSEMA | YES | NO |
| TUBERCULOSIS | YES | NO |
| SLEEP APNEA | YES | NO |

PSYCHIATRIC

| | | |
|-------------|-----|----|
| MEMORY LOSS | YES | NO |
| DEPRESSION | YES | NO |

ENDOCRINE / HEPATIC

| | | |
|------------------|-----|----|
| HORMONE PROBLEMS | YES | NO |
| THYROID DISEASE | YES | NO |
| EXCESSIVE THIRST | YES | NO |
| HEPATITIS | YES | NO |

HEMATOLOGICAL / LYMPHATIC

| | | |
|-------------------------|-----|----|
| SLOW TO HEAL AFTER CUTS | YES | NO |
| ANEMIA | YES | NO |
| LYMPHEDEMA | YES | NO |
| HIV | YES | NO |

URINARY

| | | |
|--------------------|-----|----|
| FREQUENT URINATION | YES | NO |
| BLOOD IN URINE | YES | NO |
| INCONTINENCE | YES | NO |
| IRREGULAR PERIODS | YES | NO |
| KIDNEY FAILURE | YES | NO |
| DIALYSIS | YES | NO |