PATIENT LABEL:

SURGICAL ASSOCIATES
Board Certified · General Surgery · Surgical Critical Care · Colon & Rectal Surgery

Date ___________________________

New Patient _____

Return Patient (Revision) _____

WHY ARE YOU HERE? ____

WHO REFERRED YOU TO SURGICAL ASSOCIATES? ________________________________

WHO IS YOUR PRIMARY CARE DOCTOR? ____

YOUR INTERNIST? ____________________ YOUR CARDIOLOGIST? (if any) ____________

ANY OTHER PHYSICIANS? ____

PLEASE LIST ANY SURGICAL PROCEDURES OR HOSPITALIZATIONS:

PROCEDURE/HOSPITALIZATION	WHERE/WHEN	DOCTOR	PROBLEM

(USE ADDITIONAL SPACE AT THE END OF THIS FORM IF NEEDED)

PRESENT MEDICATIONS (Please include prescription and/or over the counter medications)

MEDICATION	DOSAGE	MEDICATION	DOSAGE	MEDICATION	DOSAGE

ANY ALLERGIES TO ANY MEDICATIONS? _____ NO _____ YES please describe below what type of allergic reaction?

____

____

____

(USE ADDITIONAL SPACE AT THE END OF THIS FORM IF NEEDED)

SYSTEMS REVIEW (Please Circle if you have or have had any of the following)

General
Recent weight change
Fever/chills
Fatigue
Night Sweats

Skin and Hair
Rashes/sores
Skin cancers or melanomas
Hair loss
Unusual lumps under skin

Endocrine
Diabetes
Thyroid Disease
High Blood Pressure

Ears, Nose & Throat
Glasses/contacts
Double vision
Hearing loss
Persistent ringing in the ears
Difficulty swallowing
Pain or stiffness in the neck
Fullness in the neck or throat
Hoarseness or voice change

Lungs
Shortness of breath
Emphysema or chronic bronchitis
Asthma or wheezing
Congestive heart failure
Persistent cough
Pneumonia

Heart and Blood Vessels
Heart attacks
Chest pain
Heart murmur
Heart surgery
Irregular heart beat (palpitations)
Swelling in feet
Phlebitis or blood clots
High Blood Pressure

Gastrointestinal
Difficulty swallowing
Heartburn
Hiatal hernia
Ulcer disease
Jaundice
Hepatitis or other liver disorders
Colitis
Irritable bowel syndrome
Crohns' disease
Constipation
Diarrhea
Hemorrhoids/rectal disorders
Blood in stool
Abdominal Pain

Musculoskeletal
Arthritis
Joint pain, stiffness or swelling
Decreased muscle strength
Previous bone disease
Osteoporosis
Any broken bones
Back pain/back surgery

Neurological
Headaches
Dizziness/fainting
Weakness or tingling or arms or legs
History of any head injury

Blood
Anemia
Blood Transfusions
If yes, when, how much, and why ______

Infections
Any serious infection
Childhood illnesses: ____ measles ____ mumps
____ chicken pox
Last tetanus shot ________ Last flu shot ________

For women only:
Abnormal bleeding or discharge
Any gynecological surgery
Pain during intercourse
Kidney stones
Urinary tract infections
Sexually transmitted diseases (gonorrhea, syphilis, herpes, venereal warts, AIDS, etc.)

Age at time of first menstrual period _____

Number of pregnancies _____

Number of live births _____

Did you breast feed your children? ________ Average, how long? ____

Last menstrual period ________________________________

Breasts
Breast pain
Nipple discharge
Breast lumps
Previous breast surgery
Changes in breast size

For Men only:
Kidney stones
Prostate disease
Difficulty urinating
Urinary tract infections
Vasectomy
Sexually transmitted diseases (gonorrhea, syphilis, herpes, venereal warts, AIDS, etc.)

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, PLEASE EXPLAIN

PLEASE LIST ILLNESSES (for which you see a Doctor or take medication)

____

____

____

____

____

____

____

FAMILY HISTORY:
(please indicate if any relative has, or had)

	AGE	RELATIONSHIP
______ **Hypertension**	_____	__________________
______ **Diabetes**	_____	__________________
______ **Thyroid**	_____	__________________
______ **Heart Attack**	_____	__________________
______ **Stroke**	_____	__________________

FAMILY HISTORY OF CANCER:
(please indicate if any relative has, or had)

	AGE	RELATIONSHIP
______ **Breast Cancer**	_____	__________________
______ **Colon Cancer**	_____	__________________
______ **Ovarian Cancer**	_____	__________________

Please specify any other history of Cancer __________

____

SOCIAL HISTORY:

WHAT IS YOUR OCCUPATION? ________________________________ RETIRED ___ DISABLED ______________________

DO YOU SMOKE? ____ NO _____ YES HOW MANY PACKS A DAY ____ HOW MANY YEARS? ____

DO YOU DRINK? _____ NO ______ YES ____ BEER _____ ALCOHOL ______ DRINKS PER DAY

DO YOU DRINK COFFEE? ____ NO ___ YES _____ CUPS PER DAY

HAVE YOU EVER USED ANY STREET DRUGS SUCH AS COCAINE, MARIJUANA, ETC? ___ NO ____ YES please describe:

____

Patient
Signature: ____DATE: ___________________

SURGICAL
ASSOCIATES

Thank you for providing complete information