SurgOne, P.C.

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Medical History/Review Of Systems

Today's Date: _____

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Requesting/Referring Physician _____ Primary Physician _____

Reason for Visit (Chief Complaint): _____

History of the Present Illness: _____

List all Significant **Medical Problems**	Please list all **Medications** and their doses:
1	1 Dose
2	2 Dose
3	3 Dose
4	4 Dose
5	5 Dose
6	6 Does
7	7 Dose
8	8 Dose

List ALL **past surgeries** you have had and approx. date

1

2

3

4

Reproductive History (Please indicate number or Pregnancies and Births)

Pregnancies _____ Births _____ Lost Pregnancies _____

Allergies (Please list) are you allergic to any medicines, tape, latex, etc.

SOCIAL HISTORY

Do you smoke? _____ (if so how much per day?) _____ If you have smoked, when did you quit? _____

Do you drink alchohol? _____ (if so how many drinks per day?) _____

Do you use any non-prescribed drugs? _____ (if so, what?) _____

Are you on any type of special diet? Please describe _____

What is/was your occupation? _____

FAMILY HISTORY Please indicate if any family member (including Grandparents, Parents, Siblings) had/does have the following:

Gall bladder problems _____ Reaction to Anesthesia _____

Bleeding or clotting problems _____ Breast Cancer _____

Heart Attacks _____ Ovarian Cancer _____

Diabetes _____ Colon Cancer _____

Blood Pressure Problems _____ Any other Cancers _____

Anything else your physician should know about your health or your family's health?

MEDICAL HISTORY/REVIEW OF SYSTEMS

Have you been diagnosed with and/or are you currently having (in the last 6 months) any of the following symptoms?

Neurologic/Head, Eyes, Ears, Nose Throat

Do you have the following	NO	YES	If yes please indicate below
Numbness/tingling			
Loss of strength			
Stroke (CVA/TIA)			
Headaches-type			
MS			
Ear problems			
Eye problems			
Nose/Sinus problems			
Throat problems			

Musculoskeletal / Skin

Do you have the following	NO	YES	If yes please indicate below
Back/Neck/Joint problems			
Loss of sensation			
Rash / Skin breakdown			
Arthritis (type)			
Fractures			
Osteoporosis			
Joint Replacement			

Endocrine

Do you have the following	NO	YES	If yes please indicate below
Tired / Sluggish			
Excessive thirst			
Diabetes			
Thyroid problems			

Respiratory

Do you have the following	NO	YES	If yes please indicate below
Wheezing			
Shortness of breath			
Productive/bloody cough			
Bronchitis			
Pneumonia			
Pulmonary embolism			
Turberculosis			

Cardiac

Do you have the following	NO	YES	If yes please indicate below
Heart murmur			
Chest pain (Angina)			
Palpations / heart racing			
Congestive heart failure			
Heart attack			
High blood pressure			
Pacemaker			
Artificial Heart Valve			
Rheumatic fever			

Communicable Diseases

Do you have the following	NO	YES	If yes please indicate below
Malaria			
AIDS / HIV			
Hepatitis A / B / C			
Sexual trans disease			
Tuberculosis			

Digestive (Stomach / Bowel)

Do you have the following	NO	YES	If yes please indicate below
Abdominal pain			
Nausea / Vomiting			
Constipation/Diarrhea			
Colitis			
Diverticulitis			
Hiatal Hernia			
Reflux Esophagitis			
Irritable bowel			
Ulcers			
Pancreatitis			
Rectal bleeding or pain			
Change in bowel habits			
Cirrhosis			
Jaundice			
Hemorrhoids			
Gallstones			

Genitourinary / GYN

Do you have the following	NO	YES	If yes please indicate below
Kidney problems			
Bladder infections			
Kidney failure			
Prostate infections			
Uterine problems			
Ovarian problems			

Breast

Do you have the following	NO	YES	If yes please indicate below
Nipple discharge			
Lumps			
Pain			
Prior Surgery			

Blood / Immune System

Do you have the following	NO	YES	If yes please indicate below
Swollen lymph glands			
Anemia			
DVT / Phlebitis / Clots			
Lupus			

Cancer

Do you have the following	NO	YES	If yes please indicate below
Type			
Treatment			
Location			

Psychologic (Emotional)

Do you have the following	NO	YES	If yes please indicate below
Nervousness			
Anxiety			
Depression			
Other			

Constitutional

Do you have the following	NO	YES	If yes please indicate below
Fever			
Chills			
Weight loss			
Night Sweats			