Name: _____ Age: _____ Date of Birth: _____
Contact Information: Phone: _____ Email: _____
Primary Pharmacy: _____
Primary Doctor: _____ Phone: _____
Referring Doctor: _____ Phone: _____
Why were you referred to a surgeon? _____

What surgeries have you had in the past? What year were they done?

(1)_____ (5) _____
(2)_____ (6) _____
(3)_____ (7) _____
(4)_____ (8) _____

What are your medical problems (e.g., high blood pressure, diabetes, heart disease, etc.)?

(1)_____ (5) _____
(2)_____ (6) _____
(3)_____ (7) _____
(4)_____ (8) _____

Have you ever had a "stress test" (yes or no)? When was the last one? _____
Who is your cardiologist? _____ Phone Number: _____

Family History

Father: Alive (yes or no)? Age: _____ Medical Problems: _____
Mother: Alive (yes or no)? Age: _____ Medical Problems: _____
Siblings: How many? _____ Medical Problems: _____
Children: How many? _____ Medical Problems: _____
Is there any **history of cancer** in your family? _____
What types and who? _____

Social History

Do you smoke (yes or no)? How much (packs/day)? _____
Have you ever smoked (yes or no)? How many years? _____ When did you quit?_____
Do you drink alcohol (yes or no)? How much? _____
Do you drink more than two drinks daily (yes or no)? _____
What is your occupation? _____

Please complete both sides of this form

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Medications (Include dose & frequency)

(1)_____ (5) _____
(2)_____ (6) _____
(3)_____ (7) _____
(4)_____ (8) _____

Do you take insulin or steroids (yes or no)?

Allergies (Include the type of reaction)

(1) _____
(2) _____
(3) _____
(4) _____

Physician Notes

Examination (pertinent findings)
(completed by the physician)

CONST:
EYES:
HEENT:
NECK/THYROID:
RESP:
C/V:
CHEST/BREAST:
ABD:
GU:
LYMPHATIC:
MUSC/SKEL:
SKIN:
NEURO:
PSYCH:

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Have you gained or lost weight?	Gained/Lost
If "yes" how much weight and over what period-of- time?	Amount: _____ Time: _____
Do you ever have a fever or chills or night sweats?	Yes/No
Do you have a normal appetite?	Yes/No
Do you have nausea or vomiting?	Yes/No
Do you have diarrhea?	Yes/No
Do you have constipation?	Yes/No
Have you had a change in your bowel habits?	Yes/No
Do you ever notice blood in your stool?	Yes/No
Do you have heartburn or reflux symptoms?	Yes/No
Do you have any difficulty swallowing?	Yes/No
Do you have any hoarseness or change in your voice?	Yes/No
Do you ever have shortness of breath when resting or sleeping?	Yes/No
Have you ever had pneumonia?	Yes/No When? _____
Do you have sleep apnea?	Yes/No
Do you have a persistent cough?	Yes/No
Do you ever have chest pain, at rest or with exertion?	Yes/No
Have you had a heart attack, especially in the last six months?	Yes/No
Have you ever had a "stress test" or "heart cath"?	Yes/No When? _____
Have you ever had heart angioplasty or stents or heart surgery?	Yes/No When? _____
Do you ever have irregular heartbeats?	Yes/No
Have you ever been hospitalized with congestive heart failure?	Yes/No When? _____
Do you have swelling of your legs?	Yes/No
Have you ever had a blood clot in your legs or lungs?	Yes/No
Have you ever had surgery to improve blood flow in your legs?	Yes/No
Have you ever had hepatitis or jaundice?	Yes/No
Do you have any difficulty urinating?	Yes/No
Are you on dialysis?	Yes/No
What type? _____ What days? _____	
Do you have any family or personal history of easy bruising?	Yes/No
Have you or a family member ever had difficulty with anesthesia?	Yes/No
Do you have any history of stroke?	Yes/No
If yes, do you still have any persistent weakness or deficit?	Yes/No
Do you perform routine self-breast examinations?	Yes/No
Do you have any nipple discharge?	Yes/No

Please complete both sides of this form

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Have you received chemotherapy or radiation in the last 30 days?	Yes/No
Have you had any surgery in the last 30 days?	Yes/No
Do you have any open wounds?	Yes/No
Do you have anxiety or depression?	Yes/No
Do you live independently?	Yes/No

Physician Signature: _____ Date: _____

Please complete both sides of this form