

Surgery Group S.C.

PATIENT HISTORY AND PHYSICAL

(This form will be reviewed with you at your visit.)

DATE: _____

PATIENT NAME: _____ DOB: _____

PRIMARY CARE PHYSICIAN: _____

OTHER PHYSICIANS YOU SEE:

NAME: _____ REASON: _____

NAME: _____ REASON: _____

PREFERRED PHARMACY _____

REASON FOR YOUR VISIT TODAY: _____

IS THERE A FAMILY HISTORY OF: (Please specify who and when)

COLON CANCER Y / N _____

OTHER CANCER Y / N _____

CROHNS/COLITIS Y / N _____

COLON POLYPS Y / N _____

ANY OTHER PERTINENT FAMILY HISTORY E.G. (HYPERTENSION, DIABETES, HEART DISEASE)

HEALTH MAINTENANCE	DATE
LAST PNEUMOVAX	
LAST FLU SHOT	
LAST COLONOSCOPY	
FOR FEMALES ONLY	
LAST MAMMOGRAM	

ALLERGIES

PLEASE LIST ANY ALLERGIES TO MEDICINE, FOODS AND/OR ENVIRONMENTAL WITH REACTION

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Patient Name: _____ **Date of Birth:** _____

PATIENTS MEDICAL HISTORY (circle yes or no) Occupation _____

Alcohol/Drug Abuse	Yes	No	Cataract	Yes	No	Heart Attack	Yes	No	Nerve/Muscle Disease	Yes	No
ADD/ADHD	yes	No	Circulation Problems	Yes	No	Heartburn/GERD/	Yes	No	Osteoporosis	Yes	No
Anemia	Yes	No	colitis/Bowel Disease	Yes	No	High Blood Pressure	Yes	No	Pneumonia	Yes	No
Anxiety	Yes	No	Congestive Heart	Yes	No	HIV/AIDS	Yes	No	Seizures	Yes	No
Arthritis	Yes	No	Chronic Obstructive Pulmonary Disease	Yes	No	Jaundice	Yes	No	Sickle Cell	Yes	No
Asthma	Yes	No	Depression	Yes	No	Kidney Disease	Yes	No	Stroke	Yes	No
Birth Defect/Genetic Problem	Yes	No	Diabetes	Yes	No	Meningitis	Yes	No	Thyroid Disease	Yes	No
Blood Clots	Yes	No	Emphysema	Yes	No	Mental Health Problems	Yes	No	Tuberculosis	Yes	No
Blood Transfusion	Yes	No	Glaucoma	Yes	No	Murmur	Yes	No	Viral Hepatitis	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No						

If yes to cancer, where and when:

Other Medical History:

PATIENT'S SURGICAL HISTORY (circle yes or no)

Anal Rectal Surgery	Yes	No	Brain Surgery	Yes	No	C-Section	Yes	No	Hernia Repair	Yes	No
Appendectomy	Yes	No	Breast Surgery	Yes	No	Cholecystectomy (Gallbladder)	Yes	No	Hysterectomy	Yes	No
Surgical Repair: Broken	Yes	No	Colon Surgery	Yes	No	Adenoid/Tonsillect.	Yes	No	Joint Replacement	Yes	No
Coronary Artery Bypass Graft	Yes	No	Cosmetic Surgery	Yes	No	Sterilization	Yes	No	Ear Tubes	Yes	No

Other Surgical History:

PATIENT'S SOCIAL HISTORY

Tobacco Use			Yes	Never		Quit						
	Packs/Day	Years smoking	.25	.5	1	1.5	2	3				
Alcohol Use	Yes	No	Glass(es) of Wine					Comment _____				
			Can(s) of Beer									
			Shot(s) of Liquor									
Internal Drug Use	Yes	No						Common				
								Types				
								Marijuana	Methamphetamine			
Sexually Active	Yes	No	Not									
			Female	Male								

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PLEASE CIRCLE YES OR NO FOR THE FOLLOWING PROBLEMS:

Constitution

Fever Y/N
 Chills Y/N
 Weight Loss Y/N
 Malaise/Fatigue Y/N
 Cold Sweats Y/N
 Weakness Y/N

Cardiovascular

Chest Pain Y/N
 Palpitations Y/N
 Trouble Breathing
 Laying Flat Y/N
 Claudication Y/N
 Leg Swelling Y/N
 Trouble Breathing at Night Y/N

Musculoskeletal

Muscle Aches Y/N
 Neck Pain Y/N
 Back Pain Y/N
 Joint Pain Y/N
 Falls Y/N

Skin

Rash Y/N
 Itching Y/N

Respiratory

Cough Y/N
 Coughing Up Blood Y/N
 Sputum Production Y/N
 Shortness of Breath Y/N
 Wheezing Y/N

Endo/Heme/Allergy

Easy Bruise/Bleed Y/N
 Environ. Allergies Y/N
 Increased Thirst Y/N

HENT

Headaches Y/N
 Hearing Loss Y/N
 Tinnitus Y/N
 Ear Pain Y/N
 Ear Discharge Y/N
 Nosebleeds Y/N
 Congestion Y/N
 Stridor Y/N
 Sore Throat Y/N

Gastrointestinal

Heartburn Y/N
 Nausea Y/N
 Vomiting Y/N
 Abdominal Pain Y/N
 Diarrhea Y/N
 Constipation Y/N
 Blood in Stool Y/N
 Melena Y/N

Neurological

Dizziness Y/N
 Tingling Y/N
 Tremors Y/N
 Sensory Change Y/N
 Speech Change Y/N
 Focal Weakness Y/N
 Seizures Y/N
 Fainting Y/N

Eyes

Blurred Vision Y/N
 Double Vision Y/N
 Light Sensitivity Y/N
 Eye Pain Y/N
 Eye Discharge Y/N
 Eye Redness Y/N

Urinary

Pain with Urination Y/N
 Urgency Y/N
 Frequency Y/N
 Blood in Urine Y/N
 Flank Pain Y/N

Psychiatric

Depression Y/N
 Suicidal Ideas Y/N
 Substance Abuse Y/N
 Hallucinations Y/N
 Nervous/Anxious Y/N
 Insomnia Y/N
 Memory Loss Y/N

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signature: _____

Date: _____