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: _____

_____

HISTORY OF PRESENT ILLNESS

LOCATION _____

ONSET (When did the symptoms begin?) _____

ARE THE SYMPTOMS… (Circle all that apply.)

CONSTANT OR INTERMITTENT?

MILD, MODERATE OR SEVERE?

WORSENING WITH TIME? YES/NO

DESCRIBE PAIN IF PRESENT

SHARP DULL ACHE THROBBING GNAWING STABBING BURNING

DO THE SYMPTOMS SPREAD ELSEWHERE ON THE BODY? YES/NO

IF YES, WHERE? _____

WHAT MAKES THE SYMPTOMS/PAIN WORSE?

_____

_____

WHAT MAKES THE SYMPTOMS/PAIN BETTER?

_____

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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	.25	.5	1	1.5	2	3				
Years smoking										
Alcohol Use	Yes	No								
Drinks/week			Glass(es) of Wine				Comment			
			Can(s) of Beer							
			Shot(s) of Liquor							
Internal Drug Use	Yes	No					Commen			
Per Week							Types	Marijuana	Methamphetamine	
								Cocaine	IV	
Sexually Active	Yes	No	Not							
Gender of Partners:	Female		Male							

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DO YOU HAVE A FAMILY HISTORY OF:

(Please specify who and when)

COLON CANCER Y N _____

OTHER CANCER Y N

_____

CROHNS/COLITIS _____

COLON POLYPS _____

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 ENVIROMENT WITH REACTION

_____

_____

_____

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PLEASE CIRCLE YES OR NO FOR THE FOLLOWING PROBLEMS:

Constitution		**Cardiovascular**		**Musculoskeletal**	
Fever	Y/N	Chest Pain	Y/N	Muscle Aches	Y/N
Chills	Y/N	Palpitations	Y/N	Neck Pain	Y/N
		Trouble Breathing			
Weight Loss	Y/N	Laying Flat	Y/N	Back Pain	Y/N
Malaise/Fatigue	Y/N	Claudication	Y/N	Joint Pain	Y/N
Cold Sweats	Y/N	Leg Swelling	Y/N	Falls	Y/N
		Trouble Breathing at			
Weakness	Y/N	Night	Y/N		
				Endo/Heme/Allergy	
Skin		**Respiratory**		Easy Bruise/Bleed	Y/N
Rash	Y/N	Cough	Y/N	Environ. Allergies	Y/N
Itching	Y/N	Coughing Up Blood	Y/N	Increased Thirst	Y/N
		Sputum Production	Y/N		
HENT		Shortness of Breath	Y/N	**Neurological**	
Headaches	Y/N	Wheezing	Y/N	Dizziness	Y/N
Hearing Loss	Y/N			Tingling	Y/N
Tinnitus	Y/N	**Gastrointestinal**		Tremors	Y/N
Ear Pain	Y/N	Heartburn	Y/N	Sensory Change	Y/N
Ear Discharge	Y/N	Nausea	Y/N	Speech Change	Y/N
Nosebleeds	Y/N	Vomiting	Y/N	Focal Weakness	Y/N
Congestion	Y/N	Abdominal Pain	Y/N	Seizures	Y/N
Stridor	Y/N	Diarrhea	Y/N	Fainting	Y/N
Sore Throat	Y/N	Constipation	Y/N		
		Blood in Stool	Y/N	**Psychiatric**	Y/N
Eyes		Melena	Y/N	Depression	Y/N
Blurred Vision	Y/N			Suicidal Ideas	Y/N
Double Vision	Y/N	**Urinary**		Substance Abuse	Y/N
Light Sensitivity	Y/N	Pain with Urination	Y/N	Hallucinations	Y/N
Eye Pain	Y/N	Urgency	Y/N	Nervous/Anxious	Y/N
Eye Discharge	Y/N	Frequency	Y/N	Insomnia	Y/N
Eye Redness	Y/N	Blood in Urine	Y/N	Memory Loss	Y/N
		Flank Pain	Y/N		

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

Signature: _____ **Date:** _____