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 COLONOSCOPY	
LAST MAMMOGRAM	

ALLERGIES

PLEASE LIST ANY ALLERGIES TO MEDICINE, FOODS AND/OR ENVIROMENTAL 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	Cirrhosis	Yes	No			
If yes to cancer, where and when:											
Other Medical History:											

PATIENT'S SURGICAL HISTORY (circle yes or no and please write date of surgery)

Anal Rectal Surgery	Yes	No	Breast surgery	Yes	No	C-Section	Yes	No	Hernia Repair	Yes	No
Appendectomy	Yes	No	Colonoscopy/ Endoscopy	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		Snuff/Chew 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								
Recreational Drug Use	Yes	No					Common				
Per Week							Types	Marijuana	Methamphetamine		
								Cocaine	IV		
Sexually Active	Yes	No	Not								
Gender of Partners:	Female		Male								

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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 Night	Y/N		
Skin				**Endo/Heme/Allergy**	
Rash	Y/N	**Respiratory**		Easy Bruise/Bleed	Y/N
Itching	Y/N	Cough	Y/N	Environ. Allergies	Y/N
		Coughing Up Blood	Y/N	Increased Thirst	Y/N
		Sputum Production	Y/N		
HENT		Shortness of Breath	Y/N	**Neurological**	
Hearing Loss	Y/N	Wheezing	Y/N	Headaches	Y/N
Tinnitus	Y/N			Dizziness	Y/N
Ear Pain	Y/N	**Gastrointestinal**		Tingling	Y/N
Ear Discharge	Y/N	Heartburn	Y/N	Tremors	Y/N
Nosebleeds	Y/N	Nausea	Y/N	Sensory Change	Y/N
Congestion	Y/N	Vomiting	Y/N	Speech Change	Y/N
Stridor	Y/N	Abdominal Pain	Y/N	Focal Weakness	Y/N
Sore Throat	Y/N	Diarrhea	Y/N	Seizures	Y/N
		Constipation	Y/N	Fainting	Y/N
		Blood in Stool	Y/N		
Eyes		Melena	Y/N	**Psychiatric**	
Blurred Vision	Y/N			Depression	Y/N
Double Vision	Y/N	**Urinary**		Suicidal Ideas	Y/N
Light Sensitivity	Y/N	Pain with Urination	Y/N	Substance Abuse	Y/N
Eye Pain	Y/N	Urgency	Y/N	Hallucinations	Y/N
Eye Discharge	Y/N	Frequency	Y/N	Nervous/Anxious	Y/N
Eye Redness	Y/N	Blood in Urine	Y/N	Insomnia	Y/N
		Flank Pain	Y/N	Memory Loss	Y/N

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

Signature: _____ **Date:** _____