Progressive Surgical Associates

PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST) _____ DATE OF BIRTH _____

PRIMARY CARE PHYSICIAN _____ WHAT PHYSICIAN REFERRED YOU HERE TODAY? _____

NAME AND LOCATION OF PREFERRED PHARMACY: _____

CURRENT MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY

ARE YOU TAKING ANY BLOOD THINNING MEDICATION, I.E., PLAVIX, COUMADIN, AGGRENOX, ASPIRIN, IBUPROFEN, MOTRIN?

☐ YES ☐ NO IF YES, WHAT? _____

ARE YOU TAKING ANY DIET OR HERBAL MEDICATION?

☐ YES ☐ NO IF YES, WHAT? _____

PAST MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD:

- ☐ ABNORMAL HEART RHYTHM
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLEEDING DISORDER
- ☐ BLOOD CLOTS
- ☐ BLOOD TRANSFUSION
- ☐ CANCER
- ☐ CONGENITAL ABNORMALITY
- ☐ DIABETES
- ☐ ELEVATED CHOLESTEROL
- ☐ FIBROMYALGIA
- ☐ HEART ATTACK
- ☐ HEART FAILURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ HYPERTHYROID
- ☐ HYPOTHYROID
- ☐ KIDNEY FAILURE
- ☐ KIDNEY STONES
- ☐ LIVER PROBLEMS
- ☐ OSTEOPOROSIS
- ☐ PULMONARY EMBOLISM
- ☐ SEIZURE
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ ULCER
- ☐ CHICKEN POX
- ☐ MEASLES
- ☐ MUMPS
- ☐ RHEUMATIC FEVER

CONTINUED

DRUG ALLERGIES

PLEASE LIST ANY DRUG ALLERGIES:

_____ _____

_____ _____

PAST SURGICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?

- ☐ APPENDECTOMY
- ☐ BACK SURGERY
- ☐ BREAST SURGERY
- ☐ CATARACTS
- ☐ COLON/RECTAL SURGERY
- ☐ COLONOSCOPY
- ☐ C-SECTION
- ☐ GALLBLADDER
- ☐ GASTRIC BYPASS/BANDING
- ☐ HEART BYPASS
- ☐ HEMORRHOID SURGERY/BANDING
- ☐ HYSTERECTOMY (ABDOMINAL)
- ☐ HYSTERECTOMY (VAGINAL)
- ☐ JOINT REPLACEMENT
- ☐ OVARY REMOVAL
- ☐ TONSILLECTOMY
- ☐ OTHER: _____

FAMILY HISTORY

DO YOU HAVE THE FOLLOWING MEDICAL HISTORY IN YOUR FAMILY:

☐ CANCER ☐ HEART DISEASE

CONTINUED

SOCIAL HISTORY

MARITAL STATUS (CIRCLE ONE):

SINGLE **MARRIED** **DIVORCED** **SEPARATED** **WIDOWED**

EDUCATION (CIRCLE ONE):

HIGH SCHOOL **COLLEGE** **POST-GRADUATE**

OCCUPATION:

_____

YOUR SEXUAL PREFERENCE (CIRCLE ONE):

OPPOSITE SEX **SAME SEX** **EITHER**

DO YOU DRINK ALCOHOL?

☐ YES (HOW MUCH? _____) ☐ FORMERLY USED ALCOHOL ☐ NEVER USED ALCOHOL

DO YOU SMOKE?

☐ CURRENT SMOKER (HOW MUCH? _____) ☐ FORMER SMOKER ☐ NEVER SMOKED

FOR WOMEN:

NUMBER OF PREGNANCIES _____ NUMBER OF MISCARRIAGES _____

NUMBER OF DELIVERIES _____ NUMBER OF ABORTIONS _____

HAVE YOU EVER USED:

☐ COCAINE ☐ MARIJUANA ☐ SPEED ☐ OTHER _____

DO YOU INTAKE ANY OF THE FOLLOWING?

☐ COFFEE ☐ TEA ☐ SODA ☐ CHOCOLATE

CONTINUED

Progressive Surgical Associates

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS

RECENT WEIGHT CHANGE	☐ YES	☐ NO
FEVER	☐ YES	☐ NO
FATIGUE	☐ YES	☐ NO
HEADACHES	☐ YES	☐ NO

EYES

WEAR GLASSES/CONTACTS	☐ YES	☐ NO
BLURRED OR DOUBLE VISION	☐ YES	☐ NO

EARS/NOSE/MOUTH/THROAT

HEARING LOSS OR RINGING	☐ YES	☐ NO
NOSEBLEEDS	☐ YES	☐ NO
SORE THROAT OR VOICE CHANGE	☐ YES	☐ NO

CARDIOVASCULAR

HEART MURMUR	☐ YES	☐ NO
MITRAL VALVE PROLAPSE	☐ YES	☐ NO
RHEUMATIC FEVER	☐ YES	☐ NO
CHEST PAIN/ANGINA PECTORIS	☐ YES	☐ NO
PALPITATIONS	☐ YES	☐ NO
PACEMAKER	☐ YES	☐ NO
STROKE	☐ YES	☐ NO
HISTORY OF HEART ATTACK	☐ YES	☐ NO

RESPIRATORY

CHRONIC/FREQUENT COUGHS	☐ YES	☐ NO
EMPHYSEMA	☐ YES	☐ NO
ASTHMA	☐ YES	☐ NO
TUBERCULOSIS	☐ YES	☐ NO
PNEUMONIA	☐ YES	☐ NO

GASTROINTESTINAL

LOSS OF APPETITE	☐ YES	☐ NO
CHANGE IN BOWEL HABITS	☐ YES	☐ NO
NAUSEA OR VOMITING	☐ YES	☐ NO
FREQUENT DIARRHEA	☐ YES	☐ NO
PAINFUL BOWEL MOVEMENTS	☐ YES	☐ NO
CONSTIPATION	☐ YES	☐ NO
RECTAL BLEEDING/BLOOD IN STOOL	☐ YES	☐ NO
UNINTENTIONAL WEIGHT LOSS	☐ YES	☐ NO
JAUNDICE	☐ YES	☐ NO
VOMITING BLOOD	☐ YES	☐ NO
HISTORY OF LIVER DISEASE	☐ YES	☐ NO

GENITOURINARY

BLOOD IN URINE	☐ YES	☐ NO
INCONTINENCE OR DRIBBLING	☐ YES	☐ NO
KIDNEY STONES	☐ YES	☐ NO

MUSCULOSKELETAL

JOINT PAIN	☐ YES	☐ NO
JOINT STIFFNESS OR SWELLING	☐ YES	☐ NO
WEAKNESS OF MUSCLE/JOINTS	☐ YES	☐ NO
BACK PAIN	☐ YES	☐ NO

INTEGUMENTARY (SKIN/BREAST)

RASH OR ITCHING	☐ YES	☐ NO
VARICOSE VEINS	☐ YES	☐ NO
BREAST PAIN	☐ YES	☐ NO
BREAST LUMP	☐ YES	☐ NO
BREAST DISCHARGE	☐ YES	☐ NO

NEUROLOGICAL

CONVULSIONS OR SEIZURES	☐ YES	☐ NO
NUMBNESS OR TINGLING SENSATIONS	☐ YES	☐ NO
PARALYSIS	☐ YES	☐ NO
STROKE OR TIA	☐ YES	☐ NO

PSYCHIATRIC

NERVOUSNESS	☐ YES	☐ NO
DEPRESSION	☐ YES	☐ NO
INSOMNIA	☐ YES	☐ NO
ANXIETY	☐ YES	☐ NO

ENDOCRINE

GLANDULAR/HORMONAL PROBLEM	☐ YES	☐ NO
HEAT OR COLD INTOLERANCE	☐ YES	☐ NO
INSULIN PUMP	☐ YES	☐ NO

HEMATOLOGIC/LYMPHATIC

BLEEDING/BRUISING TENDENCY	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO
PHLEBITIS/BLOOD CLOTS IN LEGS	☐ YES	☐ NO
PAST TRANSFUSION	☐ YES	☐ NO

My signature below signifies that the information provided in this document, which includes my medical history, is true and complete, to the best of my knowledge.

PATIENT SIGNATURE_____ DATE_____