SURGICAL GROUP OF JOHNSON CITY

Name: ______________________________ Age: ______Date: ________ Referring Doctor: ________________

MEDICAL HISTORY: Please check if you have or have had any of the following:

☐ High Blood Pressure
☐ Heart Failure
☐ Heart Attack
☐ Heart Murmur
☐ Rheumatic Fever
☐ Angina
☐ Stroke
☐ Transient Ischemic Attack
☐ Seizure
☐ Vascular Disease
☐ Anemia
☐ Disc Disease
☐ Veneral Disease
☐ Aneurysm
☐ Urinary Stress Incontinence
☐ Bleeding Disorder
☐ Kidney Stone
☐ Kidney Infection
☐ Prostate Trouble
☐ Emphysema
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Tuberculosis
☐ Anesthetic Problem
☐ Collapsed Lung
☐ Diabetes
☐ Thyroid Problems
☐ Lupus
☐ Polycystic Ovarian Syn.
☐ Phlebitis
☐ Breast Problems
☐ Cancer of any Kind
☐ Hodgkins Disease
☐ Leukemia
☐ Fibroids
☐ Pelvic Infections
☐ Adrenal Gland Problem
☐ Varicose Veins
☐ Hernia
☐ Irritated Bowel
☐ Ulcer Disease
☐ Panceratitis
☐ Hepatitis
☐ Hyperlipidemia
☐ Cirrhosis
☐ Gallbladder Problem
☐ Ulcerative Colitis
☐ Crohns Disease
☐ Bowel Obstruction
☐ Rectal Problem
☐ Hemorrhoids
☐ Arthritis
☐ Blood Clots
☐ Depression
☐ Head Injury
☐ Eye Disease
☐ Sleep Apnea
☐ Hypercholesterolemia
☐ GERD (Reflux)
☐ Fibromyalgia

Are you pregnant or any possibility of being pregnant? ________________________________ ________________
Number of Pregnancies: ____________ Number of Children: __________ Number of Miscarriages: _______________
Age of First Period: __________________ Last Period: __________________ Last Pap Smear: ___________________
Last mammogram: _________________
Previous Surgeries: ____
____
____
Medications: ____
____
____
Allergies: ____
Social History: Smoke: Yes _______ No _______ Alcohol: Yes _______ No _______
History of Family Health Problems: Father ______________________ Brothers ________________________
History of Family Health Problems: Mother ______________________ Sisters _________________________
History of Family Health Problems: Grandparents ____

REVIEW OF SYSTEMS: Please check if you have or in the past had any of the following:

SKIN:
☐ Easy Bruising
☐ Changing Moles

LYMPH:
☐ Enlarged Node
☐ Gland Swelling

ENDOCRINE:
☐ Increased Thirst
☐ Intolerance To Temp
☐ Increased Urination
☐ Weight Loss

HEENT:
☐ Convulsions
☐ Severe Headaches
☐ Vision Changes
☐ Nose Bleeds
☐ Speech Difficulty
☐ Hoarseness

BREAST:
☐ Lumps
☐ Nipple Discharge
☐ Pain or Enlargement

CHEST:
☐ Pain
☐ Shortness of Breath
☐ Wheezing
☐ Cough, Dry Mucus/Blood
☐ Night Sweats
☐ Fever or Chills
☐ Irregular Heart Beat

G.I:
☐ Abdominal Pain
☐ Indigestion
☐ Nausea or Vomiting
☐ Decreased Appetite
☐ Jaundice
☐ Change in Bowels
☐ Rectal Trouble
☐ Or Bleeding

G.U:
☐ Bulge in Groin
☐ Impotence
☐ Problem with urination
☐ Abn. Vaginal Bleeding

EXT:
☐ Leg Pain w/Walking
☐ Cold Feet
☐ Swelling

Have you ever received a Blood Transfusion? Yes _______ No _______
Do you take Aspirin daily? Yes _______ No _______
Do you take Hormones or Birth Control Pills? Yes _______ No _______
Do you have Dentures? Yes _______ No _______