Watauga Surgical Group, P.A.

Name:_____ **DOB:** _____ **Date:** _____

Past Medical History

Circle Yes or No

Have You Ever Had:			**Year**
Anemia	Yes	No	
Arthritis	Yes	No	
Asthma	Yes	No	
Blood Clot/ DVT/ PE	Yes	No	
Blood Transfusion	Yes	No	
Bronchitis	Yes	No	
Cancer	Yes	No	
Diabetes	Yes	No	
Emphysema	Yes	No	
Fibromyalgia	Yes	No	
Heart Attack	Yes	No	
Heart Disease	Yes	No	
Hepatitis	Yes	No	
High Blood Pressure	Yes	No	
Hx of MRSA	Yes	No	
Kidney Disease	Yes	No	
Pneumonia	Yes	No	
Reflux	Yes	No	
Stroke	Yes	No	
Tuberculosis	Yes	No	
Ulcer	Yes	No	
Other	Yes	No	

Specify _____

Operations			**Year**
Appendix	Yes	No	
Breast	Yes	No	
Colon	Yes	No	
Gallbladder	Yes	No	
Heart	Yes	No	
Hernia	Yes	No	
Prostate	Yes	No	
Stomach	Yes	No	
Thyroid	Yes	No	
Ovary	Yes	No	
Uterus	Yes	No	
Other Surgery	Yes	No	

Specify _____

Family History-Has any blood relative had any of the following. Circle "Yes" or "No", If yes, what relationship

Cancer	Yes	No	_____
Colon Polyps	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Thyroid Trouble	Yes	No	_____

Social History

Smoking	Yes	No	packs per day _____
Snuff	Yes	No	Former Smoker year quit _____
Chewing Tobacco	Yes	No	
Alcohol	Yes	No	
Drugs	Yes	No	

Diagnostic Test

Colonoscopy Yes No Date _____
Where performed _____
Mammogram Yes No Date _____
Where performed _____

CURRENT MEDICATIONS

Medication Name	**Dosage**	**Frequency**

MEDICATION ALLERGY	**REACTION**

LATEX ALLERGY □ **YES** □ **NO**

Watauga Surgical Group, P.A.

Patient Name:_____ **DOB:** _____ **Date:**_____

Primary Care Physician _____
Referring Physician _____

Pharmacy Name _____
Address _____
Phone _____

Have you <u>recently</u> had the following: Circle Yes or No; if in doubt, leave blank.

REVIEW OF SYSTEMS

GENERAL

Fever	Yes	No
Weakness	Yes	No
Night Sweats	Yes	No

EYES

Vision Changes	Yes	No
Double vision	Yes	No

EARS, NOSE, THROAT

Post nasal drip	Yes	No
Hoarseness	Yes	No

CARDIOVASCULAR

Chest Pain	Yes	No
Palpitations	Yes	No

RESPIRATORY

Cough	Yes	No
Hemoptysis (coughing up blood)	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Difficulty breathing while lying down	Yes	No
Phlegm	Yes	No

GASTROINTESTINAL

Abdominal pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Change in Bowel Habits	Yes	No
Tarry (black) stools	Yes	No
Rectal Bleeding	Yes	No
Gas/Bloating	Yes	No
Indigestion/Heartburn	Yes	No
Dysphagia (difficulty swallowing)	Yes	No
Changes in appetite	Yes	No
Vomiting blood	Yes	No

GENITOURINARY

Dysuria (painful urination)	Yes	No
Hematuria (blood in urine)	Yes	No
Difficulty with urination	Yes	No
Frequent urination	Yes	No

VASCULAR

Varicose veins R/L	Yes	No
Leg swelling R/L	Yes	No
Pain in calf when walking R/L	Yes	No
Pain in toes at night R/L	Yes	No

MUSCULOSKELETAL

Muscle weakness	Yes	No
Back pain	Yes	No

DERMATOLOGY

Jaundice	Yes	No
Rash	Yes	No

NEUROLOGICAL

Fainting	Yes	No
Paralysis	Yes	No
Frequent headaches	Yes	No

HEMATOLOGY

Abnormal bruising	Yes	No
Excessive bleeding	Yes	No

PSYCHIATRIC

Depression	Yes	No
Anxiety	Yes	No

ENDOCRINOLOGY

Cold intolerance	Yes	No
Heat intolerance	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No