PATIENT NAME _____ DATE _____ REFERRING MD _____

Your Primary Care Physician _____ Phone # _____

Your Cardiologist _____ Phone # _____

* BRIEFLY DESCRIBE REASON FOR YOUR VISIT * _____

Medical History	yes	no
diabetes	❑	❑
high blood pressure	❑	❑
sleep apnea (c-pap)	❑	❑
seizures	❑	❑
pneumonia	❑	❑
asthma	❑	❑
tuberculosis	❑	❑
emphysema	❑	❑
kidney disease _____	❑	❑
hepatitis A B C	❑	❑
liver disease	❑	❑
stomach ulcers	❑	❑
arthritis	❑	❑
anemia	❑	❑
thyroid _____	❑	❑
phlebitis	❑	❑
HIV	❑	❑
diverticulitis	❑	❑
colon cancer	❑	❑
gyn cancer - site _____	❑	❑
melanoma - site _____	❑	❑
other cancer - site _____	❑	❑
mental health _____	❑	❑
dementia	❑	❑

Any other information you feel may be important to the doctor _____

Surgical History	yes	no
gallbladder	❑	❑
appendectomy	❑	❑
hernia repair	❑	❑
hemorrhoidectomy	❑	❑
colon surgery	❑	❑
orthopedic surgery	❑	❑

If yes, body part _____

Titanium or Metal

Other surgery _____

Cardiac History	yes	no	year
cardiac surgery	❑	❑	
type			
pacemaker	❑	❑	
defibrillator	❑	❑	
stents	❑	❑	
heart attack	❑	❑	
heart valve disease	❑	❑	
irregular heartbeat	❑	❑	
stroke	❑	❑	

Social History	yes	no	If yes, amount
cigarette smoking	❑	❑	
cigar or pipe smoking	❑	❑	
alcohol use	❑	❑	

Quit/When _____

Family History	yes	no	Relative
melanoma	❑	❑	
diabetes	❑	❑	
heart disease	❑	❑	
colon cancer	❑	❑	
ovarian cancer	❑	❑	
breast cancer	❑	❑	
uterine cancer	❑	❑	

other _____

Female Patients please answer the following:

Date of last menstrual period _____

Date of last breast exam by a physician _____

Date of last mammogram _____

Age of first menstrual period _____

	yes	no
Personal history of breast cancer	❑	❑
Previous breast surgery:	❑	❑
biopsy	❑	❑
lumpectomy	❑	❑
mastectomy	❑	❑
implants	❑	❑

other _____

Please check yes or no for each of the following if you have experienced within the last 2 months

	yes	no		yes	no		yes	no
unexplained weight loss	❑	❑	incontinence	❑	❑	excessive gas	❑	❑
change in a skin lesion	❑	❑	chest pain	❑	❑	hemorrhoids	❑	❑
persistent headache	❑	❑	ankle swelling	❑	❑	indigestion	❑	❑
nosebleeds	❑	❑	palpitations	❑	❑	jaundice	❑	❑
neck pain	❑	❑	difficulty urinating	❑	❑	nausea	❑	❑
chronic cough	❑	❑	blood in urine	❑	❑	vomiting	❑	❑
wheezing	❑	❑	black or tarry stool	❑	❑	dizziness	❑	❑
breast mass	❑	❑	blood in stool	❑	❑	easy bruising	❑	❑
nipple discharge	❑	❑	constipation	❑	❑	back pain	❑	❑
gout	❑	❑	diarrhea	❑	❑			

Immunizations up to date? yes❑ no❑

Pneumonia vaccine? ❑yes ❑ no date _____

Colonoscopy last 5 years yes❑ no❑

Foreign travel within last year? yes❑ no❑

Pregnancy History / number of pregnancies _____

number of live births _____

Atlantic Surgical Group

List Medications /Vitamins/Supplements

(Please Print)

Patient Name_____ **Date:**_____

Local Pharmacy Name_____ **Location**_____

LATEX ALLERGY: Yes or No - If yes: Airborne or Touch **Do you take aspirin or blood thinner? YES NO**

ALLERGIES TO MEDICATIONS_____

Name of Medication (Print)	Dosage	Frequency taken

If you need additional sheets, we will be happy to provide them for you. Please ask the receptionist.