

CHARLOTTE SURGICAL GROUP, P.A.

Patient's Medical History

Name: _____

Patient #: _____

Date: _____

D.O.B.: _____ Age: _____ Height: _____ Weight: _____



PATIENT LABEL

Confidential Record: The information contained herein will not be released unless you have authorized us to do so.

Who is your Primary Care Doctor?

Name and Group: _____

Address: _____

Referring Doctor: _____

Reason for your visit: _____

Past Medical History:

Check if **you** have had any of the following medical problems

- | | |
|--|---|
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Breast Problem | Type _____ |
| Describe: _____ | Treatment: |
| _____ | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Previous Breast Biopsies? | <input type="checkbox"/> Chemotherapy |
| Results: _____ | <input type="checkbox"/> Diabetes |
| _____ | <input type="checkbox"/> Thyroid disease/goiter |
| <input type="checkbox"/> Skin Diseases | <input type="checkbox"/> Glaucoma |
| Type _____ | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Artificial eye |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Caps, crowns, bridges |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Loose teeth |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Irregular rhythm | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Diverticulosis/ diverticulitis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irritable bowel |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Blood Clots/Bleeding disorder | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Depression or mental illness | Schedule: M T W Th F |
| | <input type="checkbox"/> Stones |
| | <input type="checkbox"/> Gout |
| | <input type="checkbox"/> Allergies |
| | <input type="checkbox"/> Migraine headaches |
| | <input type="checkbox"/> Scleroderma |

List any of your medical problems not covered above or provide details for those checked above:

Operations: List and indicate approx. dates

Date of most recent general anesthesia:

Have you ever had any problems with general anesthesia? Yes No

Describe: _____

Do you have any family history of problems with general anesthesia? Yes No

Describe: _____

Hospitalizations (other than operations): List reasons and approx. dates

Serious Injuries (other than above): List and give approx. dates

Women: Number of pregnancies: _____

Number of live births: _____

Number of miscarriages/abortions: _____

Your age at first live birth: _____

Your age at first menstrual cycle: _____

Do you take oral contraceptives? Yes No

Do you take hormones? Yes No

PATIENT NAME: _____

Medications:

Please list all medications and dosages, **including** vitamins, dietary supplements, herbal remedies, and over-the-counter medications.

Do you take Aspirin? Yes No _____

Do you take Blood Thinners? Yes No _____

Are you **allergic** to any medications? Yes No If yes, please list medications and the **reaction** that you had to them: _____

Any history of steroid use? Yes No When? _____

Social History & Personal Habits:

Occupation: _____

Marital Status: Married Single
 Divorced Widowed

Check if you regularly drink: Yes No

If "Yes":

- Hard Liquor: 1-3 oz. per day Over 3 oz. per day
- Wine: 1 glass per day 2 glasses 3 or more
- Beer: 1 bottle per day 2 bottles 3 or more

Do you smoke? Yes No
 If "Yes", number of packs per day: _____
 For how many years? _____

Do you have a history of street drug use? Yes No

Have you ever required a blood transfusion? Yes No

Are you concerned that you may be at risk for HIV? Yes No

Family History:

			Medical Problems	If Deceased:	
	Circle Gender	Age		Age at Death	Cause
Father					
Mother					
Brothers / Sisters	M F				
	M F				
	M F				
	M F				
	M F				
	M F				

Do any of the following run in your family?

- Heart Disease
- Bleeding Disorder
- Cancer

Type _____ Type _____

Type _____ Type _____

Review of Systems:

Please indicate if you have experienced any of the following symptoms **in the past 6 months:**

General

- | | Yes | No |
|--|--------------------------|--------------------------|
| Have you recently experienced fevers, chills, or sweats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has there been any unusual weight gain or loss recently? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any change in appetite? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you regularly have trouble sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |

Skin

- Have you noticed:
- | | | |
|---|--------------------------|--------------------------|
| Any growth on your skin that bothers you? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any change in color or size of moles? | <input type="checkbox"/> | <input type="checkbox"/> |

EENT

- Do you have:
- | | | |
|--------------------------------|--------------------------|--------------------------|
| Frequent or severe nosebleeds? | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in vision? | <input type="checkbox"/> | <input type="checkbox"/> |

Lymphatics

- | | | |
|--------------------------------|--------------------------|--------------------------|
| Any swollen glands/lymph nodes | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------------|--------------------------|--------------------------|

Endocrine

- | | | |
|---------------------------|--------------------------|--------------------------|
| Any hot/cold intolerance? | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent urination? | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive thirst? | <input type="checkbox"/> | <input type="checkbox"/> |
| Other glandular problem? | <input type="checkbox"/> | <input type="checkbox"/> |
- Specify: _____

Respiratory

- Do you have:
- | | | |
|--|--------------------------|--------------------------|
| Persistent or bothersome cough? | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath or difficulty breathing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you cough up blood? | <input type="checkbox"/> | <input type="checkbox"/> |

Cardiovascular

- Do you have:
- | | | |
|--|--------------------------|--------------------------|
| Pain, tightness, or pressure in your chest? | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling in your feet or ankles? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in the calf muscle or buttocks when you walk? | <input type="checkbox"/> | <input type="checkbox"/> |
| An irregular heartbeat? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty lying flat to sleep? | <input type="checkbox"/> | <input type="checkbox"/> |

Gastrointestinal

- | | Yes | No |
|--|--------------------------|--------------------------|
| Do you have a lot of indigestion or heartburn? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any problem swallowing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent nausea and/or vomiting? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you persistently bothered with constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent loose stools or diarrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you noticed any recent Changes in your bowel movements? | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in your stool? | <input type="checkbox"/> | <input type="checkbox"/> |

Genitourinary

- | | | |
|---|--------------------------|--------------------------|
| Do you have burning or pain when you urinate? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever passed blood in your urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have difficulty urinating? | <input type="checkbox"/> | <input type="checkbox"/> |

Musculoskeletal

- | | | |
|---|--------------------------|--------------------------|
| Do you have joint pain, stiffness, or swelling? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

Central Nervous System

- | | | |
|--|--------------------------|--------------------------|
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had convulsions or seizures? | <input type="checkbox"/> | <input type="checkbox"/> |

Women only:

- | | | |
|--|--------------------------|--------------------------|
| Are you currently having menstrual cycles (periods)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your menstrual periods irregular? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you passed the menopause or "change of life"? | <input type="checkbox"/> | <input type="checkbox"/> |
| Age at menopause: _____ | | |
| Do you have hot flashes or vaginal dryness? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any lumps in your breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any discharge from your nipples not associated with pregnancy or breastfeeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any breast pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you leak urine when you cough, sneeze or laugh? | <input type="checkbox"/> | <input type="checkbox"/> |

Health Maintenance:

Please note the approximate **date** and **result** of your most recent:

Complete Physical Exam Never
Date: _____ Result: _____

Treadmill Stress Test Never
Date: _____ Result: _____

Hemoccult Never
Date: _____ Result: _____

Sigmoidoscopy/Colonoscopy Never
Date: _____ Result: _____

Women:

Pap Smear Never
Date: _____ Result: _____

Mammogram Never
Date: _____ Result: _____

Do you perform Self Breast Exams? Yes No

Men:

Prostate Examination Never
Date: _____ Result: _____

Thank you for your complete and honest answers to these important health questions. All of this information will be kept confidential by your health care providers. By signing below, you certify that the information above is true to the best of your knowledge.

Patient Signature

Physician Signature

Date