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