

SURGICAL GROUP OF JOHNSON CITY

Name: _____ Age: _____ Date: _____ Referring Doctor: _____

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Gallbladder Problem |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Cancer of any Kind | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Hodgkins Disease | <input type="checkbox"/> Crohns Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Bowel Obstruction |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Rectal Problem |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pelvic Infections | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Transient Ischemic Attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Adrenal Gland Problem | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Anesthetic Problem | <input type="checkbox"/> Hernia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Collapsed Lung | <input type="checkbox"/> Irritated Bowel | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Disc Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Eye Disease |
| <input type="checkbox"/> Veneral Disease | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Panceratitis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Lupus | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Urinary Stress Incontinence | <input type="checkbox"/> Polycystic Ovarian Syn. | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> GERD (Reflux) |
| | | | <input type="checkbox"/> 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: | HEENT: | CHEST: | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Pain | <input type="checkbox"/> Change in Bowels |
| <input type="checkbox"/> Changing Moles | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Rectal Trouble |
| LYMPH: | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Or Bleeding |
| <input type="checkbox"/> Enlarged Node | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Cough, Dry Mucus/Blood | G.U.: |
| <input type="checkbox"/> Gland Swelling | <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Bulge in Groin |
| ENDOCRINE: | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Increased Thirst | BREAST: | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Problem with urination |
| <input type="checkbox"/> Intolerance To Temp | <input type="checkbox"/> Lumps | G.I.: | <input type="checkbox"/> Abn. Vaginal Bleeding |
| <input type="checkbox"/> Increased Urination | <input type="checkbox"/> Nipple Discharge | <input type="checkbox"/> Abdominal Pain | EXT: |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Pain or Enlargement | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Leg Pain w/Walking |
| | | <input type="checkbox"/> Nausea or Vomiting | <input type="checkbox"/> Cold Feet |
| | | <input type="checkbox"/> Decreased Appetite | <input type="checkbox"/> 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 _____