SOUTHERN SURGICAL ASSOCIATES

Today's Date:_____

FOR OFFICE USE ONLY: ☐ NEW PATIENT ☐ ESTABLISHED PATIENT

Wt:_____ Ht:_____ BMI:_____ IBW:_____ B/P:_____ Pulse:_____Resp:_____

To Be Completed by Patient (please print):

Name_____ Date of Birth_____ Age_____ Gender_____

Last First

CHIEF COMPLAINT:

Why are you here today?_____ How long have you had the problem?_____

Do you have any pain? _____ Scale: _____/10 Type: Burning/Stabbing/Sharp/Dull/Cramping/Shooting

PAST MEDICAL HISTORY:

Y N

CARDIO/PULMONARY

☐ ☐ Asthma
☐ ☐ COPD
☐ ☐ Emphysema
☐ ☐ Heart Attack *Date*_____
☐ ☐ Heart Disease
☐ ☐ Heart Murmur
☐ ☐ High Blood Pressure
☐ ☐ High Cholesterol
☐ ☐ PE/DVT
☐ ☐ Sleep Apnea *C-Pap or Bi-Pap*

Cardiologist Name_____
Pulmonologist Name_____

GASTROINTESTINAL

☐ ☐ Barrett's Esophagus
☐ ☐ Cirrhosis
☐ ☐ Diverticulitis
☐ ☐ Hepatitis *Type*_____
☐ ☐ Hiatal Hernia
☐ ☐ IBS
☐ ☐ Liver Disease
☐ ☐ Pancreatitis
☐ ☐ Reflux
☐ ☐ Ulcer

Y N

HEMATOLOGY

☐ ☐ Anemia
☐ ☐ Bleeding Disorders

ENDOCRINE/RENAL

☐ ☐ Diabetes
☐ ☐ Hyperthyroid
☐ ☐ Hypothyroid
☐ ☐ Kidney Disease
☐ ☐ Kidney Failure

MUSCULAR/SKELETAL

☐ ☐ Arthritis
☐ ☐ Fibromyalgia
☐ ☐ Gout
☐ ☐ Rheumatoid Arthritis
☐ ☐ Use cane/walker/wheelchair

NEUROLOGICAL

☐ ☐ Anxiety
☐ ☐ Bipolar
☐ ☐ Depression
☐ ☐ Migraines
☐ ☐ Seizures *Date*_____
☐ ☐ Stroke *Date*_____

CANCER

☐ ☐ Breast

Y N

☐ ☐ Colon
☐ ☐ Gastric
☐ ☐ Leukemia
☐ ☐ Lymphoma
☐ ☐ Prostate
☐ ☐ Other_____

GE

☐ ☐ Infertility
☐ ☐ PCOS
☐ ☐ Stress Incontinence
☐ ☐ Irregular Menses

OTHER

☐ ☐ Connective Tissue Disease
☐ ☐ HIV/AIDS
☐ ☐ Lupus
☐ ☐ Sarcoidosis

Other:_____
_____
_____
_____

SOUTHERN SURGICAL ASSOCIATES

REVIEW OF SYSTEMS: (Tell us what you are currently experiencing or feeling)

Y N

GENERAL

☐ ☐ Weight Loss
☐ ☐ Weight Gain
☐ ☐ Fever
☐ ☐ Night Sweats
☐ ☐ Fatigue

EYES

☐ ☐ Blurred Vision
☐ ☐ Double Vision
☐ ☐ Corrective Lenses
☐ ☐ Glaucoma
☐ ☐ Cataracts

EARS/NOSE/MOUTH/THROAT

☐ ☐ Ringing in Ears
☐ ☐ Sinus Trouble
☐ ☐ Swollen Glands in Neck
☐ ☐ Hearing Loss
☐ ☐ Bleeding Gums
☐ ☐ Nose Bleeds

CARDIOVASCULAR

☐ ☐ Chest Pain
☐ ☐ Heart fluttering/racing
☐ ☐ Heart Murmur
☐ ☐ Leg Swelling
☐ ☐ Venous Insufficiency

Y N

RESPIRATORY

☐ ☐ Shortness of Breath
☐ ☐ Wheezing
☐ ☐ Persistent Cough
☐ ☐ Spitting up Blood
☐ ☐ Pneumonia

GASTROINTESTINAL

☐ ☐ Nausea
☐ ☐ Vomiting
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Rectal Bleeding
☐ ☐ Black Stools
☐ ☐ Trouble Swallowing
☐ ☐ Heartburn
☐ ☐ Loss of Appetite

HEMATOLOGIC/LYMPHATIC

☐ ☐ Easy Bruising
☐ ☐ Enlarged Glands

ENDOCRINE/RENAL

☐ ☐ Thyroid Problems
☐ ☐ Excessive Thirst or Urination
☐ ☐ Hormone Problem
☐ ☐ Heat/Cold Intolerance

MUSCULAR/SKELETAL

☐ ☐ Back Pain

Y N

☐ ☐ Muscle Cramping
☐ ☐ Cold Extremities
☐ ☐ Joint Pain
☐ ☐ Pain in Legs with Walking

NEUROLOGICAL

☐ ☐ Seizures
☐ ☐ Stroke
☐ ☐ Numbness/tingling
☐ ☐ Headache

INTEGUMENTARY

☐ ☐ Rash
☐ ☐ Lesions
☐ ☐ Itching

GENITOURINARY

☐ ☐ Pain with Urination
☐ ☐ Blood in Urine
☐ ☐ Frequent Urination
☐ ☐ Difficult Catheterization
☐ ☐ Urinary Tract Infection

ALLERGY/IMMUNOLOGIC

☐ ☐ Seasonal Allergies
☐ ☐ Frequent or Unusual Infections

FAMILY HISTORY:

	Living	Deceased	Age	Health Problems/Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

SOUTHERN
SURGICAL ASSOCIATES

SURGICAL/PROCEDURE HISTORY:

	When		When
Appendectomy		Gastric Bypass	
Back Surgery		Gastric Sleeve	
C-Section		Hemorrhoidectomy	
CABG		Hip Replacement	
Cardiac Bypass		Hysterectomy	
Cardiac Cath		Knee Replacement	
Carpal Tunnel		Lap or Open Gallbladder	
Cataract		Mastectomy	
Colonoscopy		Nissen (reflux surgery)	
Colon Resection		Pace Maker	
Defibrillator		Tonsillectomy	
Endoscopy		Tubal Ligation	
Gastric Band		Other	
Gastric Band Removal		Other	

SOCIAL HISTORY:

Tobacco Use: ☐ Never ☐ Previously but quit ☐ Daily *Amount:*_____ Type: ☐ Cigarettes ☐ Chew ☐ Snuff
Alcohol Use: ☐ Never ☐ Rare ☐ Moderate ☐ Frequent
Street Drug Use: ☐ No ☐ Yes *Type/Frequency*:_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Occupation:_____ ☐ Full Time ☐ Part Time

ALLERGIES:

☐ None

Name of Medication	Type of Reaction

MEDICATIONS:

Medication	Dose/Strength	How Often?

I declare that the above information is accurate to the best of my knowledge.

_____ _____
Signature Date