Surgical Associates, P.A.

Date ____________________

HISTORY AND PHYSICAL EXAM

NAME: ______________________________ Age ____________ Date of birth ___________________

Primary or referring Physician: ____

Reason for your visit: ____

CURRENT MEDICATIONS: (prescription and over the counter)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Do you take Aspirin? ____________________

Medication Allergies: ____

PAST OPERATIONS:
(list, including dates)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

PAST MEDICAL HISTORY:
(problems seen, treated for – include hospitalizations, injuries, childbirth, etc.)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

PLEASE FILL OUT THE OTHER SIDE ALSO

(OVER)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Question		
1. Have you had a persistent cough for more than 3 weeks?	Y	N
2. Have you been coughing up bloody sputum (saliva)?	Y	N
3. Night sweats?	Y	N
4. Unexplained weight loss?	Y	N
5. Fever?	Y	N

PERSONAL MEDICAL HISTORY: (please circle yes or no – give details below if yes)

High blood pressure	Y	N	Diabetes	Y	N
Irregular heart rhythm	Y	N	Thyroid disease	Y	N
Chest pain	Y	N	Asthma	Y	N
Heart attack	Y	N	Urinary/kidney issues	Y	N
Congestion heart failure	Y	N	Bowel habit changes	Y	N
Shortness of breath	Y	N	Abdominal pain	Y	N
Chronic cough	Y	N	GERD/reflux	Y	N
Pneumonia	Y	N	Ulcers	Y	N
Leg swelling	Y	N	Weight loss/gain	Y	N
Blood clots	Y	N	Hepatitis	Y	N
Bleeding problems	Y	N	Stroke	Y	N

ANY PROBLEMS WITH ANESTHESIA? Y N

Do you have any ADVANCED DIRECTIVES (living will, durable power of attorney for healthcare,

Do Not Resuscitate?) Yes__________ No___________ If so, please list _________________________

____

SOCIAL HISTORY:

Tobacco use:	No	Yes	How much?
Drug use:	No	Yes	How much?
Alcohol use:	No	Yes	How much?

FEMALE HISTORY ONLY:

Age at first period? ____________________________

Number of pregnancies, deliveries? ______________

Last menstrual cycle? __________________________

Birth control pills, hormones? _________________

Age at first live birth? _________________________

Age at menopause? _____________________________

MALE HISTORY ONLY:

Prostate problems? _________________________________

Difficulty with urination? ___________________________

FAMILY HISTORY: Give ages and known major illnesses

Father _______________________________________ Mother _______________________________________

Siblings ____

List any family member with:

Cancer _______________________________________ Diabetes _____________________________________

Heart Disease _________________________________ Kidney disease ________________________________

Bleeding problems _____________________________ Anesthesia problems ___________________________