Surgical Associates, P.A.

HISTORY AND PHYSICAL FORM **Date:** _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Referring Physician: _____ **Primary Physician:** _____

Reason for your visit: _____

MEDICATIONS

Please list the medication(s) that you are currently taking to include prescription and non-prescription.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES (Please include reaction to allergen)

☐ I do not have any allergies **Latex Allergy:** Yes No

_____
_____
_____

SURGERIES AND/OR HOSPITALIZATIONS

☐ I have not had any surgery.

Type of Surgery/Reason for Hospitalization	Date

Medical History (please mark all that apply)

☐ None of these apply to me

☐ High Blood Pressure
☐ Diabetes
☐ High Cholesterol
☐ Thyroid Disease
☐ Anemia
☐ Asthma
☐ Gallbladder Problems
☐ Sleep Apnea
☐ Bladder Problems
☐ Prostate Problems
☐ Intestinal/Bowel Problems
☐ Heart Disease/Heart Attack
☐ Bleeding or Bruising
☐ Cancer, Type_____
☐ DVT/Blood clots
☐ Seizures
☐ Weight loss/Weight gain
☐ Reaction to Anesthesia
☐ Abdominal pain
☐ Hepatitis
☐ Lung Problems
☐ Kidney Problems
☐ Tuberculosis
☐ Stroke/TIA
☐ Thyroid Disease
☐ Ulcer
☐ VRE/MRSA/Staph Infection
☐ Congestive Heart Failure
☐ Osteoporosis
☐ GERD/Indigestion
☐ Mental Illness
☐ HIV/AIDS
☐ Liver Disease

OVER

Medical History- continued

Please provide any specifics here: _____

_____

Are there any other medical problems that we should be aware of? _____

_____

Social History

Do you smoke cigarettes? Yes No If yes: Number of packs per day_____ for _____ years.

If no, do you use any other tobacco products? Yes No Type of tobacco: _____

Do you consume alcoholic beverages? Yes No Amount and frequency: _____

Do you use recreational drugs? Yes No Type and frequency: _____

Other: _____

Female History

Age at first period: _____ Date of last menstrual cycle: _____
Number of pregnancies: _____ Number of deliveries: _____
Birth control pills, hormones: _____ Age at menopause: _____

Family History

☐ I do not know my family history

(*for grandparents, aunts, and uncles, please indicate "M" for mother's side or "P" for father's side)

Condition	Family Member	Condition	Family Member	Condition	Family Member
☐ **Cancer**		☐ **Hypertension**		☐ **Thyroid**	
☐ **Diabetes**		☐ **Stroke**		☐ **Anesthesia**	
☐ **Heart Disease**		☐ **Bleeding**		☐ **Kidney**	

If there is a family history of cancer, please provide name of type of cancer and age at which your family member was diagnosed.

_____

_____

_____