Patient History Form

Surgical Clinic Associates, P.A

Patient Name: _____ **Date:** _____

Date Of Birth: _____ **Age:** _____

Reason for Visit: _____

Referring Doctor: _____

Past Medical History

- ☐ Abnormal Weight Gain
- ☐ Abnormal Weight Loss
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Angina
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Bronchitis
- ☐ **Cancer** List Type_____
- ☐ _____
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Diabetes Mellitus (Type I) (Type II) (Unkn)
- ☐ Diverticulitis of Colon
- ☐ Esophageal Reflux
- ☐ Free Bleeder
- ☐ Heart Palpitations
- ☐ Heart Attack (Previous Myocardial Infarction)
- ☐ Hepatitis (A, B, or C) -- Circle One
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Obesity
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Sleep Apnea
- ☐ Stroke (Cardiovascular Accidents)
- ☐ Ulcerative Colitis
- ☐ Vascular Disease

Past Surgical History — Surgery Dates

- ☐ Adenoids _____
- ☐ Appendix _____
- ☐ Back Surgery _____
- ☐ Brain Surgery _____
- ☐ Breast Surgery _____
- ☐ Colon Surgery _____
- ☐ C-Section _____
- ☐ Gall Bladder _____
- ☐ Heart Surgery _____
- ☐ Hemorrhoids _____
- ☐ Hernia Operation _____
- ☐ Hysterectomy _____
- ☐ Lung Surgery _____
- ☐ Reflux Surgery _____
- ☐ Thyroid _____
- ☐ Tonsils _____
- ☐ Vascular Surgery _____
- ☐ Other _____ _____

Family History — Relation to Patient

- ☐ Breast Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Colon Cancer _____
- ☐ Heart Attack _____
- ☐ Sickle Cell Anemia _____

Medication Allergies

Medication_____ Reaction_____ None____

Medication_____ Reaction_____

Habits

- ☐ Smoking amount_____ None ____
- ☐ Alcohol amount_____

Reproductive History

- ☐ Number of Pregnancies_____

Signature: _____ **Date:** _____

I, the above signed patient, have answered these questions to the best of my knowledge.