SURGICAL GROUP OF GAINESVILLE
NORTH FLORIDA REGIONAL HEALTHCARE

Name: _____

Date of Birth: _____ Age: _____

Why are you here to see the doctor? _____

Primary Care Physician: _____

Referring Physician: _____

Past Medical History

Circle any of the following conditions you have been diagnosed with:

☐ High Blood Pressure	☐ Heart Disease	☐ High Cholesterol	☐ Diabetes
☐ Thyroid Problems	☐ Kidney Problems	☐ Stroke	☐ Liver Disease/Cirrhosis
☐ Hepatitis C	☐ HIV/AIDS	☐ Asthma	☐ Emphysema/COPD
☐ Sleep Apnea	☐ Arthritis	☐ Reflux (Heartburn)	☐ Bleeding Disorder

Have you ever been diagnosed with cancer (circle)? ☐ Yes ☐ No

If yes, what type? _____

Past Surgical History

List all operations you have had with approximate dates performed

_____

_____

_____

_____

_____

_____

_____

Medications

List all medications that you take including over-the-counter medications and supplements:

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

List all known allergies: _____

_____

Social History

Marital status (circle): ☐Single ☐Separated ☐Married ☐Divorced ☐Widowed

Do you have children (circle)? ☐Yes ☐No If yes, how many? _____

What is your highest level of education? _____

What is your occupation? _____

Do you smoke cigarettes (circle)? ☐Yes ☐No ☐I used to

If yes or if you are a former smoker, how many packs per day? _____

For how many years? _____ For former smokers, when did you quit? _____

Do you drink alcohol (circle)? ☐Yes ☐No ☐Rarely

If yes, how many drinks per day? _____

Family History

Are you adopted? ☐Yes ☐No

Is your father alive? ☐Yes ☐No (if deceased, at what age?) _____

Is your mother alive? ☐Yes ☐No (if deceased, at what age?) _____

Have any of your family member been diagnosed with the following (check all that apply)

	Father	Mother	Brothers	Sisters
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Emphysema/COPD	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
If so, what type	_____	_____	_____	_____

Has anyone else in your extended family (ie aunts, uncles, or grandparents) been diagnosed with significant medical problems? If so, what type? _____

_____

_____

_____

Has anyone in your immediate family had a problem with anesthesia? If so, please describe.

_____

_____

Review of Systems

(circle all that apply)

General
- Fevers
- Chills
- Weight Loss
- Weight Gain
- Fatigue

Skin
- Rashes
- Itching
- New or Changing Moles

Head
- Headaches

Eyes
- Glasses or Contacts
- Vision Changes
- Double Vision

Ears
- Decreased Hearing
- Ringing in Ears
- Earaches

Nose
- Nosebleeds
- Nasal Drainage

Throat
- Dry Mouth
- Sore Throat

Neck
- Swollen Glands
- Stiffness
- Pain
- Lumps

Breast
- Lumps
- Pain
- Drainage
- Skin Changes

Respiratory
- Shortness of Breath
- Cough
- Wheezing
- Coughing Blood
- Asthma

Cardiac
- Chest Pain
- Irregular Heartbeat
- Palpitations
- Leg Swelling
- Shortness of Breath If Flat

Gastrointestinal
- Abdominal Pain
- Difficulty Swallowing
- Nausea
- Vomiting
- Change in Bowel Habits
- Constipation
- Diarrhea
- Blood in Stools
- Change in Appetite
- Rectal Pain
- Rectal Drainage

Urinary
- Frequency
- Urgency
- Incontinence
- Pain When Urinating
- Blood in Urine

Vascular
- Calf Pain When Walking
- Leg Cramps

Musculoskeletal
- Muscle Pain
- Joint Pain
- Stiffness
- Back Pain

Neurologic
- Dizziness
- Fainting
- Seizures
- Weakness
- Loss of Consciousness
- Numbness
- Tingling
- Tremor
- Speech Problems

Hematologic
- Easy Bruising
- Easy Bleeding
- Blood Clots

Endocrine
- Heat Intolerance
- Cold Intolerance
- Sweating
- Excessive Thirst

Psychiatric
- Memory Loss
- Depression
- Anxiety