Patient Label

General Surgery

To be certain that we have your updated and current information in your computerized health record.

Fill out both sides of this form and give to my medical assistant.

Please provide your medication list and or any new medications, OTC medications or vitamins you may be taking to my medical assistant.
Thank you for allowing us to participate in your care.

What would you like to address during your visit today*:*

1. ***2.***

Check the appropriate box if you have any of the following Symptoms

Constitutional	Eyes	Gastrointestinal	Endo/Heme/Allergy
Fever	Blurred Vision	Heartburn	Easy Bruising
Chills	Double Vision	Nausea	Environmental Allergies
Weight Loss	Sensitive to Light	Abdominal pain	Excessive Thirst
Excessive Sweating	Eye Pain	Diarrhea	**Neurological**
Fatigue	Eye Discharge	Constipation	Dizziness
Weakness	Eye Redness	Blood in Stool	Tingling
Skin	**Cardiovascular**	Black Stools	Tremor
Rash	Chest Pain	**Genitourinary**	Sensory Change
Itching	Palpitations	Dysuria	Speech Change
Head, Ears, nose, Throat	Shortness of Breath	Urgency	Focal Weakness
		Urinary Stress Incontinence	
Headaches	Pain in Legs	Frequency	Seizures
Hearing Loss	Leg Swelling	Blood in urine	Loss of Consciousness
Ringing in Ears	**Respiratory**	Flank Pain	**Psychiatric**
Ear Pain	Cough	**Musculoskeletal**	Depression
Ear Discharge	Coughing up Blood	Muscle Pains	Suicidal Ideas
Nosebleeds	Sputum	Neck Pain	Substance Abuse
Congestion	Short of Breath	Back Pain	Hallucinations
Sore Throat	Wheezing	Joint Pain	Anxiety
			Insomnia
			Memory Loss

☐ **Women ONLY.** [ ] Breast Lump / Pain [ ] Abnormal Vaginal Bleeding / Discharge [ ] Hot Flashes
☐ Date of your last Pap Month________ Year _______ Last Pap Normal / Abnormal

HAS ANY RELATIVE HAD THE FOLLOWING:
- ❑ Alzheimer's
- ❑ Anemia/Low Blood Count
- ❑ Lung Problems
- ❑ Cancer, Breast
- ❑ Cancer, Colon
- ❑ Cancer, Prostate
- ❑ Cancer, Other
- ❑ Heart Disease
- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Diabetes
- ❑ Blood Clots
- ❑ Hearing Loss
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Other

SELF CARE

Please check if you NEED HELP with any of these activities:

[ ] Dressing
[ ] Cooking meals
[ ] Bathing
[ ] Walking
[ ] Transportation

Do you currently have any of these Advance Directive forms?

[ ] Living Will
[ ] Durable Power of Attorney for Healthcare
[ ] Physician Orders for Life SustainingTreatment (POLST)

Please list all previous breast surgery including biopsy, lumpectomy, mastectomy, breast augmentation or reduction and which side it was on: left, right or both.

Do you take any hormone medications? [ ] Birth control pills
[ ] Estrogen replacement (Premarin, Estrace, Estra tabs)
[ ] Progesterone or Provera
Have you reached menopause? Y / N
At approximately what age? _____
How many pregnancies have you had? _____
How many children have you had? _____

Social History

EXERCISE:
Type ________________
____
____
How often? ____________

SMOKING:
Packs per day _____
No of years _____
Year stopped _____
☐ Pipe ☐ Cigar ☐ Chew

ALCOHOL:
Drinks per day _____
Drinks per week _____
Alcohol problem: ☐ Yes ☐ No

CHRONIC ILLNESSES HOSPITALIZATION

____

____

DRUG ALLERGIES OR REACTIONS

____
____
____

Breast History

Date of your last mammogram? Month ______ Year ________
☐ Does not apply
Have you had a provider breast exam within one year?
Yes No

Please list all previous breast surgery including biopsy, lumpectomy, mastectomy, breast augmentation or reduction and which side it was on: left, right or both.

____

Breast History Information (if applicable)

Do you take any hormone medications?
[ ] Birth Control
[ ] Estrogen replacement Premarin,Estrace,Estra
[ ] Progesterone or Provera
Approximately how old were you when you began having menstrual periods? _____
Have you reached menopause?
[ ] No [ ] Yes At approximately what age? _____
How many pregnancies have you had? _____
How many children have you had? _____

Please circle all situations that apply:
- I found a lump in my breast Left Right Both
- My doctor found a lump in my breast Left Right Both
- My last mammogram was abnormal Left Right Both
- My last ultrasound was abnormal Left Right Both

Please circle all symptoms that apply and indicate when you first noticed it:
- Pain in the breast : Left Right Both
- Non-bloody nipple discharge : Left Right Both
- Bloody nipple discharge : Left Right Both
- Dimpled skin on the breast Left Right Both
- Nipple inversion : Left Right Both
- Prominent veins on the breast : Left Right Both

Colon Cancer Screening Guidelines: Colonoscopy age 50, repeat every 10 years	Year of my last colonoscopy ________________ ☐ Does not apply