

# South Orange County Surgical Medical Group, Inc

## Patient Data and History form

Name:  
Date of birth:  
Internist:  
Marital status: Blank  
Phone number:

Why are you seeing the doctor today, please describe symptoms.

### Personal History: (Have you ever had...?)

	Yes	No		Yes	No
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia/Lung infection	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Other bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones/disease	<input type="checkbox"/>	<input type="checkbox"/>
Bladder disease/infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problem	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Phelbitis, blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Vericose veins	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

**Other medical problems:** none

### Medications (please include dose)

- |    |    |
|----|----|
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |
| 7. | 8. |

**Allergies to medications (please list):** none

**Aspirin or other blood thinners:** none

### Surgeries:

- |    |    |
|----|----|
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |

**Hospitalizations:**

- |    |    |
|----|----|
| 1. | 2. |
| 3. | 4. |

**Social history/habits:**

How much do you smoke? none  
 How many years do you (did you) smoke? 0  
 How much alcohol do you drink? none

**Family history:**

Any family members with Cancer? No  
 Any family members with diabetes? No  
 Any family members with bleeding or anesthesia problems? No

**Review of symptoms:** (have you **recently** had these symptoms)

	Yes	No		Yes	No
<u>General</u>					
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Appetite loss	<input type="checkbox"/>	<input type="checkbox"/>			
<u>ENT</u>					
Eye disease/visual change	<input type="checkbox"/>	<input type="checkbox"/>	Ear disease/hearing change	<input type="checkbox"/>	<input type="checkbox"/>
Nose/sinus problems	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Neck</u>					
Enlarged neck gland(s)	<input type="checkbox"/>	<input type="checkbox"/>	Goiter/thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardiorespiratory</u>					
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/pressure	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
<u>Gastrointestinal</u>					
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Black or bloody stool	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowels habits	<input type="checkbox"/>	<input type="checkbox"/>	Change in eating habits	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>			

	Yes	No		Yes	No
<u>Genitourinary</u>					
Increase frequency	<input type="checkbox"/>	<input type="checkbox"/>	Burning with urination	<input type="checkbox"/>	<input type="checkbox"/>
Wake up to urinate at night	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
<u>Extremities</u>					
Pain in leg with walking	<input type="checkbox"/>	<input type="checkbox"/>	Bone/joint pain	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
<u>Neurological</u>					
Visual change/loss	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in extremities	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in extremities	<input type="checkbox"/>	<input type="checkbox"/>	Problems with speech	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>			

**Recent x-ray or CT scans**

Any other information to share with your doctor?

Thank you for taking the time to complete this form in its entirety. This will allow your surgeon to have a more complete understanding of your current medical problem.