Medical History Form

Patient's Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Referring Physician/Provider: _____

Reason for Visit: _____

Have you previously been treated for this condition? ☐ Yes ☐ No

If "Yes," when and by whom _____

Were ☐ X-rays, ☐ MRI, ☐ CT scans, or ☐ endoscopies obtained? ☐ Yes ☐ No If "Yes," where? _____

Medications

Do you take: Aspirin? ☐ Yes ☐ No Arthritis Medication? ☐ Yes ☐ No Coumadin (Warfarin)? ☐ Yes ☐ No
Plavix (Clopidigrel)? ☐ Yes ☐ No Other blood thinner? ☐ Yes ☐ No *If "yes," please list:*

What is your preferred pharmacy?	**Location or phone #:**
Name of Medication / Dose / Frequency	

Medical History

Please check any current or past medical problems

☐ High Blood Pressure	☐ Asthma	☐ HIV/AIDS	☐ Colon Polyps
☐ Diabetes	☐ Tuberculosis	☐ Breast Cancer	☐ MRSA Infection
☐ Irregular Heartbeat	☐ Lung Cancer	☐ Skin Cancer	☐ Blood Clots
☐ Congestive Heart Failure	☐ Stroke	☐ Vascular Disease	☐ Leg Pain
☐ Heart Valve Replacement	☐ Seizures	☐ Hepatitis	☐ Leg Swelling
☐ Heart Attack	☐ Swallowing Trouble	☐ Liver Disease/Cirrhosis	☐ Leg Ulcers
☐ Reflux/GERD / Heartburn	☐ Kidney Disease	☐ Colon Cancer	☐ Varicose Veins
☐ COPD/Emphysema	☐ Thyroid Disorder	☐ Other (*please specify*):	
☐ High Cholesterol	☐ Sleep Apnea / CPAP		

Are you allergic to any medications? ☐ Yes ☐ No *If so, please list along with reaction:*

Are you allergic to Latex? ☐ Yes ☐ No	Are you allergic to Iodine? ☐ Yes ☐ No

Surgical History

Surgery / Approx. Date / Surgeon	**Surgery / Approx. Date / Surgeon**
Have you ever had a colonoscopy? ☐ Yes ☐ No *If "yes," when?*	

Have any of your immediate family members had: *If "yes," please list relation:*

Breast Cancer? ☐ Yes ☐ No	Thyroid Disorder? ☐ Yes ☐ No
Colon Cancer? ☐ Yes ☐ No	Bleeding Disorders? ☐ Yes ☐ No

Social History

Do you smoke cigarettes? ☐ Yes ☐ No ☐ In the past *How many packs per day?* *For how many years?*	
Do you drink alcohol? ☐ Yes ☐ No	Do you use other tobacco products? ☐ Yes ☐ No ☐ In the past

Albany Surgical, P.C.

New Patient-Review of Systems

PLEASE CHECK APPROPRIATE BOX

☐ REVIEWED ☐ REVIEWED AND ALL NEGATIVE

Have you recently had any of the following? (Circle all that apply)

- Generalized: Fever / chills / night sweats / weakness / fatigue / loss of appetite / excessive weight loss / excessive weight gain
- Eyes: New visual problems / blindness / visual changes / eye pain
- HEENT: Difficulty swallowing / ear pain / hoarseness / nasal congestion / nasal bleeding / sore throat / ringing in ears
- Respiratory: Shortness of breath / cough / increased mucous production / coughing blood / wheezing / sleep apnea / short of breath during activity
- Cardiovascular: Chest pain / heart palpitations / leg cramps while walking / calf pain or swelling / leg swelling / varicose veins
- GI: Nausea / vomiting / diarrhea / constipation / acid reflux / abdominal pain / rectal bleeding / change in bowel habits / hemorrhoids /yellow skin or eyes
- Urinary: painful urination/ blood in urine / difficulty urinating / excessive urination / incontinence / urinary retention
- Hem/Lymph: Anemia / bruising tendency / bleeding tendency / swollen lymph nodes
- Endocrine: Excessive thirst / night-time urination / change in hair texture / excessive hunger / hyperglycemia / hypoglycemia
- Immunologic: History of chemotherapy / steroid treatment / immunocompromised / recurrent fevers or infections / transplant history
- Musculoskeletal: Back pain / neck pain / joint pain / muscle cramps / muscle weakness / difficulty walking / joint redness/ joint swelling
- Skin: Rash / itching / burns / skin lesions / scars / keloids / skin masses
- Neurologic: Altered mental status / abnormal balance / confusion / cognitive impairment / numbness / tingling / dizziness / headache / memory loss / seizures / speech problems / passing out (syncope) / vertigo
- Psychiatric: Anxiety / depression / hallucinations / personality disorders / attention deficit disorders / sleeping problems / eating disorders