Albany Surgical PC

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? ☐ No ☐ Yes- (when and by whom? _____)

Were ☐X-rays, ☐MRI, ☐CT scans, ☐Ultrasounds, or ☐ Endoscopies performed? ☐ No ☐Yes- (where? _____)

Have you or anyone in your home tested positive for COVID? ☐ No ☐Yes- (☐Self ☐Other -when? _____)

Medications & Allergies

Do you take: Aspirin? ☐No ☐Yes Arthritis Meds? ☐No ☐Yes Coumadin (warfarin)? ☐No ☐Yes

Plavix (clopidogrel)? ☐No ☐Yes Any other blood thinner? ☐No ☐Yes -(what?_____)

What is your preferred pharmacy? _____ Location? _____

Name of Medications / Dose / Frequency: **We will make a copy of your list of medications if you have one.**

_____

_____

Are you allergic to ANY MEDICATIONS? ☐No ☐Yes- (what meds and reaction? _____)

Are you allergic to any LATEX? ☐No ☐Yes **Are you allergic to IODINE?** ☐No ☐Yes

Medical History

Please check any current or past medical problems.

☐ High Blood Pressure	☐ Asthma	☐ Vascular Disease
☐ High Cholesterol	☐ COPD/Emphysema	☐ Blood Clots
☐ Diabetes	☐ Tuberculosis	☐ Blood Clotting Disorder
☐ Irregular Heart Beat	☐ Sleep Apnea/ CPAP	☐ Leg Pain
☐ Heart Attack	☐ Swallowing Trouble	☐ Leg Swelling/Edema
☐ Heart Valve Replacement	☐ Reflux/GERD/Heartburn	☐ Leg Ulcers
☐ Congestive Heart Failure	☐ Thyroid Disorder	☐ Varicose Veins
☐ Stroke	☐ Kidney Disease	☐Other:
☐ Seizures	☐ Liver Disease/Cirrhosis	Have any of ***YOUR IMMEDIATE FAMILY MEMBERS*** had the following? ☐ Heart disease ☐Stroke ☐Cancer ☐Blood Clotting Disorders ☐Complications with anesthesia
☐ Colon Polyps	☐ Hepatitis	
☐ Colon Cancer	☐ MRSA Infection	
☐ Breast Cancer	☐ HIV/AIDS	
☐ Lung Cancer	☐ Other infectious disease	

Surgical & Medical Procedure History

Surgery or Procedure /Date/Physician	Surgery or Procedure /Date/Physician
	Colonoscopy? ☐No ☐Yes- (When? _____)

Social History

Do you smoke cigarettes? ☐No ☐**Past** ☐Current: Packs per day _____ How many years? _____	
Do you VAPE or Chew Tobacco? ☐No ☐**Past** ☐Current	Do you drink Alcohol? ☐No ☐**Past** ☐Current

FLIP FORM AND FILL OUT BOTH SIDES

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Patient – Review of Systems

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

☐REVIEWED ☐REVIEWED AND ALL NEGATIVE

- **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 / constipations / 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

Would you like electronic access to your health information through our patient portal?
☐NO ☐YES – ASK for information on how to get started.

FLIP FORM AND FILL OUT BOTH SIDES