ASSOCIATED SURGICAL SPECIALISTS PATIENT HISTORY

NAME:	CHART#	DATE: / /

GENERAL INFORMATION

Date of Birth	/ /
Sex	
Race	
PCP (Family Doctor)	
Who Referred You?	
Cardiologist?	

PLEASE LIST YOUR MEDICATIONS

	Drug Name	Dose
☐	NONE	

PLEASE LIST YOUR ALLERGIES

	Drug Name	Reaction
☐	NONE	
☐	Penicillin	
☐	Sulfa	
☐	Latex	
☐	Iodine – X-ray Dye	

PLEASE LIST YOUR SURGERIES

	Year		Name of Operation
☐	NONE		

HISTORY

	Personal History	
☐	NONE	
☐	Smoking	
☐	Do you drink alcohol?	
☐	Do you drink coffee?	Cups/day?
☐	What is your current weight?	

DO YOU HAVE ANY OF THESE COMPLAINTS?

	Condition	
☐	Unexplained Weight Loss	
☐	Chest Pain	
☐	Difficulty Breathing	
☐	Nausea and Vomiting	
☐	Diarrhea	
☐	Constipation	
☐	Rectal Pain	
☐	Rectal Bleeding	

DO YOU HAVE A HISTORY OF THE FOLLOWING?

	Condition	
☐	COUMADIN therapy	
☐	PLAVIX therapy	
☐	Migraine Headaches	
☐	Blindness	
☐	Deafness	
☐	Hypertension	
☐	Cardiac Valve Replacement	Type?
☐	Coronary Artery Disease	
☐	Heart Attack (MI)	
☐	Pacemaker	
☐	ICD-Defibrillation Unit	
☐	Deep Vein Thrombosis or Pulmonary Embolus	
☐	Asthma	
☐	Pneumonia	
☐	Chronic Obstructive Pulmonary Disease (COPD)	
☐	Cirrhosis	
☐	Hepatitis	Type?
☐	Chronic Renal Failure	
☐	Dialysis	
☐	Artificial Joint Surgery	Type?
☐	Transient Ischemic Attack	
☐	Stroke	
☐	Seizures	
☐	Diabetes	
☐	Thyroid Disorder	
☐	HIV Positive	
☐	Bleeding Disorder	
☐	Refuse blood products	

FAMILY HISTORY

☐ No significant Family History

Family Member	Medical Condition
Mother	
Mother's Mother	
Mother's Father	
Father	
Father's Mother	
Father's Father	
Brothers	#
Sisters	#
Children	#
Aunts	
Uncles	

NOTES

CHIEF COMPLAINT

In your own words what is the reason that you were referred to this office for evaluation?

OFFICE USE

☐ I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my doctor, or any other member of his staff responsible for any errors or omissions that I may have made in completion of this form

SIGNATURE

DATE / / /