Coastal Surgical Group

Name: _____ Date: _____

The following information is correct to the best of my knowledge. I will not hold my doctor or any of his staff members responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature: _____ DOB: _____

Past Medical History

Please check all that apply.

	Unremarkable		Hepatitis: B__C___		Thyroid dysfunction
	Heart Attack		HIV/AIDS		Cancer: Type_____
	Stroke		High cholesterol		Ulcers
	COPD		Asthma		Acid Reflux
	Diabetes		Tuberculosis		Liver disease
	High blood pressure		Prostate problems		Other
	Kidney disease		Urinary incontinence		
	Peripheral vascular disease		Psychiatric Illness		

Past Surgical History

Please check all that apply.

	Unremarkable		Inguinal hernia
	Appendix		Umbilical hernia
	Gallbladder		Ventral hernia
	Heart surgery		Colon surgery
	Carotid surgery		Orthopedic surgery
	C-section		Vascular surgery
	Hysterectomy		Other
	Thyroid surgery		

Medications

Please list all medications you are currently taking and dosage if known.

Allergies

No known drug allergies___

If yes, list allergies below and type of reaction

Family History

	Unremarkable		Kidney Disease		Crohn's/Ulcerative colitis
	Heart disease		Breast cancer		Other
	Liver disease		Thyroid cancer		
	Colon cancer		Colon polyps		
	Diabetes		High blood pressure		
	Stroke		Prostate cancer		

Do you smoke: yes____ no____ former smoker__. If yes, how many packs per day:___

Do you drink alcohol: yes___ no___ Beer___Wine___Liquor___ How much_____

Are you employed: yes___ no___ If yes, what type of work_____

Review of Systems

Please check if you have any of the following symptoms

	Chest pain		Difficulty swallowing		Skin rashes
	Shortness of breath		Heartburn/reflux		Easy bleeding/bruising
	Pain with urination		Pain in legs with walking		Prostate problems
	Constipation		Shortness of breath while lying flat		Vaginal bleeding
	Blood in stool		Blurry vision		Numbness/tingling in arms/legs
	Blood in urine		Headaches		Other