NORTH FLORIDA surgeons Volusia Division

Specializing in the Practice of Surgery
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Name: _____ DOB: _____ Age: _____ Date: _____

Why are you seeing the doctor today?

_____

_____

When did this condition start? _____
What level of severity do you feel your illness/condition is: □ Minimal □ Moderate □ Severe
Is the problem getting better, worse, or staying the same? □ Better □ Worse □ Same
Does anything else make it better or worse? _____
Have you noticed any other symptoms that you feel are related to your illness/condition?
□ No □ Yes If yes, what? _____

Please answer Yes or No if you have these significant medical problems (past and present):

Diabetes	□ Yes	□ No		Seizure / Convulsion	□ Yes	□ No		TIA	□ Yes	□ No
Hypertension	□ Yes	□ No		Bleeding tendency	□ Yes	□ No		Stroke	□ Yes	□ No
Cancer	□ Yes	□ No		Heart attack / angina	□ Yes	□ No		COPD	□ Yes	□ No
Ulcers	□ Yes	□ No		Cirrhosis	□ Yes	□ No		HIV	□ Yes	□ No

List any other significant medical problems (past and present) not listed above.

_____ _____
_____ _____
_____ _____

Please list all previous surgical procedures and dates: □ Too Many to List- *See attached* □ None- *I've never had surgery*

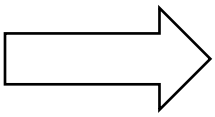
Procedure:	Year:	Where:

Please list all current medications, including any vitamins or herbal remedies: □ Too Many to List- *See attached* □ None

Medication:	Dosage:	How often:

Do you take any of the following blood thinners?

Aspirin	□ Yes	□ No	Coumadin	□ Yes	□ No	Plavix	□ Yes	□ No
Aggrenox	□ Yes	□ No	Effient	□ Yes	□ No	Pradaxa	□ Yes	□ No



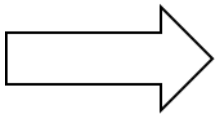
This review of system is to identify any risk factors that may complicate your surgical care. Any problems/concerns identified should be discussed by you with your primary healthcare provider.

Patient Medical History (please check Yes or No if you currently have or had in the past):

Allergic/Immunologic Allergist:		
History of skin reaction or other adverse reactions to:		Reaction:
Penicillin or other antibiotics	□ Yes □ No	
Morphine, Demerol or other narcotics	□ Yes □ No	
Novocain or other anesthetics	□ Yes □ No	
Aspirin or other pain remedies	□ Yes □ No	
Tetanus antitoxin or other serums	□ Yes □ No	
Tetanus antitoxin or other serums	□ Yes □ No	
Selfish	□ Yes □ No	
Latex	□ Yes □ No	

Constitutional- Primary Care Doctor:	
Good general health lately	□ Yes □ No
Recent weight change (gain/loss)	□ Yes □ No
Fever	□ Yes □ No
Fatigue	□ Yes □ No
Headache	□ Yes □ No
Eyes	
Eye disease or injury	□ Yes □ No
Wear glasses or contact lens	□ Yes □ No
Blurred vision	□ Yes □ No
Ears/Nose/Mouth/Throat- ENT:	
Hearing Loss	□ Yes □ No
Chronic sinus problem or rhinitis	□ Yes □ No
Nose bleeds	□ Yes □ No
Difficulty swallowing	□ Yes □ No
Bad breath or bad taste	□ Yes □ No
Sore throat or voice change	□ Yes □ No
Cardiovascular- Cardiologist:	
Previous Heart attack	□ Yes □ No
Chest pain or angina	□ Yes □ No
Irregular heart beat	□ Yes □ No
Shortness of breath with walking	□ Yes □ No
Swelling of feet, ankles or hands	□ Yes □ No
Previous coronary artery bypass	□ Yes □ No
Previous angioplasty	□ Yes □ No
Respiratory-Pulmonologist:	
Persistent or frequent coughs	□ Yes □ No
Shortness of breath	□ Yes □ No
Asthma or wheezing	□ Yes □ No
Difficulty breathing	□ Yes □ No
Neurological- Neurologist:	
Frequent or recurring headaches	□ Yes □ No
Light headed or dizziness	□ Yes □ No
Convulsions or seizures	□ Yes □ No
Numbness or tingling sensations	□ Yes □ No
Tremors	□ Yes □ No
Paralysis	□ Yes □ No
Generalized weakness	□ Yes □ No
Previous □ stroke □ TLA - When:	

Gastrointestinal- Gastroenterologist:	
Loss of appetite	□ Yes □ No
Change in bowel movements	□ Yes □ No
Nausea and/or vomiting	□ Yes □ No
Rectal bleeding or blood in stool	□ Yes □ No
Recent abdominal pain	□ Yes □ No
Frequent constipation	□ Yes □ No
Frequent diarrhea	□ Yes □ No
Frequent heartburn	□ Yes □ No
Frequent indigestion	□ Yes □ No
Liver problems	□ Yes □ No
Genitourinary- Urologist:	
Gynecologist:	
Frequent urination	□ Yes □ No
Burning or painful urination	□ Yes □ No
Blood in urine	□ Yes □ No
Change in fore or strain when urinating	□ Yes □ No
Incontinence or dribbling	□ Yes □ No
Kidney stones	□ Yes □ No
Kidney disease	□ Yes □ No
Male- prostate enlargement	□ Yes □ No
Male- testicle pain	□ Yes □ No
Female- Date of last menstrual period:	
Female- Number of pregnancies:	
Musculoskeletal- Orthopedic:	
Arthritis or joint pain	□ Yes □ No
Joint stiffness or swelling	□ Yes □ No
Weakness of muscles or joints	□ Yes □ No
Muscle pains or cramps	□ Yes □ No
Back pain	□ Yes □ No
Cold extremities	□ Yes □ No
Discomfort/Weakness when walking	□ Yes □ No
Integumentary- Dermatologist:	
Rash or itching	□ Yes □ No
Jaundice	□ Yes □ No
Varicose veins	□ Yes □ No



Endocrine- Endocrinologist:	
Glandular or hormone problem	□ Yes □ No
Thyroid problem	□ Yes □ No
Diabetes	□ Yes □ No
Excessive thirst or urination	□ Yes □ No
Heat or cold intolerance	□ Yes □ No
Hematological/Lymphatic	
Slow to heal after cuts	□ Yes □ No
Bleeding or bruising tendency	□ Yes □ No
Anemia	□ Yes □ No
Past blood transfusion	□ Yes □ No

Psychiatric- Psychologist/Psychiatrist:	
Memory loss or confusion	□ Yes □ No
Nervousness	□ Yes □ No
Depression	□ Yes □ No
Insomnia	□ Yes □ No
Anything else we should know?	

Social History: □ Married □ Divorced □ Widowed □ Separated □ Partnership □ Single □ Minor

What is/ was your occupation? _____
Retied? □ Yes □ No For how long?_____
Any special interests? _____

Personal habits: (check all that apply)
□ Currently use tobacco- Type: □ Cigarettes □ Cigars □ Pipe □ Smokeless tobacco Amount/day: _____ Years:_____
□ Former smoker: Amount/day: _____ Years: _____ Quit date: _____
□ Consume alcohol: Type: _____ Amount/day: _____
□ Use recreational drugs: Type: _____ Amount/day: _____
□ Consume caffeine Beverage: _____ Amount/day: _____
□ Exercise regularly: Type: _____ Frequency/week: _____

Family history:

Member	Age	State of Health	If Deceased, Cause
Father			
Mother			
Brother(s)			
Sister(s)			

Who referred you? □ Self □ Family □ Friend □ Physician- _____

Patient signature: _____ Date: _____

Patient name of patient: _____

Legal guardian/representative: _____ Relationship: _____

Staff Use Only

Physician reviewed: _____ Date: _____