

SurgOne, P.C.

Dr. Eric O. Kortz

Dr. Richard Tillquist

Dr. Thomas Heffron

Today's Date: _____

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Requesting/Referring Physician: _____ Primary Doctor _____

Reason for visit (Chief Complaint) _____

History of the Present Illness: _____

List of all Significant Medical Problems

Please List all Medications and their doses

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

List All past surgeries you've had and approx. date

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Reproductive History (please indicate number of pregnancies and births)

Pregnancies _____ Births _____ Lost Pregnancies _____

Allergies (please list) are you allergic to any medicine, latex, tape, etc.

Social History:

Do you smoke? _____ (if so, how much per day) _____ If you have smoked, when did you quit? _____

Do you drink alcohol? _____ (if so, how many drinks per day?) _____

Do you use any non-prescribed drugs? _____ (if so, what?) _____

Are you on any type of special diet? (If so, please describe) _____

What is/was your occupation? _____

Family History- Please indicate if any family member (including Grandparents, Parents, Siblings) had/does have the following:

Gallbladder problems _____

Reaction to Anesthesia _____

Bleeding or Clotting _____

Breast Cancer _____

Heart attacks _____

Ovarian Cancer _____

Diabetes _____

Colon Cancer _____

Any other Cancer _____

Anything else your Physician should know about your family's health? _____

SurgOne,P.C.-Medical history/Review of symptoms

Have you been diagnosed with and/or are currently having any of the following symptoms (in the last six months)

****Place a check mark ONLY by those that apply****

Neurological/Head, Ears, Nose, Throat

Do you have any of the following **NO YES** if yes please indicate below

Numbness/Tingling _____
Loss of Strength _____
Stroke(CVA/TIA) _____
Headaches-type _____
MS _____
Ear problems _____
Eye problems _____
Nose/Sinus problems _____
Throat problems _____

Musculoskeletal/Skin

Do you have any of the following **NO YES** if yes please indicate below

Back/Neck/Joint problems _____
Loss of Sensation _____
Rash/Skin Breakdown _____
Arthritis _____
Fractures _____
Osteoporosis _____
Joint Replacement _____

Endocrine

Do you have any of the following **NO YES** if yes please indicate below

Tired/Sluggish _____
Shortness of Breath _____
Bloody Cough _____
Bronchitis _____
Pneumonia _____
Pulmonary Embolism _____
Tuberculosis _____

Cardiac

Do you have any of the following **NO YES** if yes please indicate below

Heart Murmur _____
Chest Pain (angina) _____
Palpations/Heart Racing _____
Congestive Heart Failure _____
Heart attack _____
High blood pressure _____
Pacemaker _____
Artificial heart valve _____
Rheumatic fever _____

Communicable Diseases

Do you have any of the following **NO YES** if yes please indicate below

Malaria _____
Aids/HIV _____
Hepatitis _____
Sexual Trans Disease _____
Tuberculosis _____

Digestive

Do you have any of the following **NO YES** if yes please indicate below

Abdominal Pain _____
Nausea/Vomiting _____
Constipation/Diarrhea _____
Colitis _____
Diverticulitis _____
Hiatal Hernia _____
Reflux Esophagitis _____
Irritable Bowel _____
Ulcers _____
Pancreatitis _____
Rectal Bleeding or Pain _____
Change in bowel habits _____
Cirrhosis _____
Jaundice _____
Hemorrhoids _____
Gallstones _____

Genitourinary/GYN

Do you have any of the following **NO YES** if yes please indicate below

Kidney Problems _____
Bladder Infections _____
Kidney Failure _____
Prostate Infections _____
Uterine Problems _____
Ovarian Problems _____

Breast

Do you have any of the following **NO YES** if yes please indicate below

Nipple Discharge _____
Lumps _____
Pain _____
Prior Surgery _____

Blood/Immune System

Do you have any of the following **NO YES** if yes please indicate below

Swollen Lymph Glands _____
Anemia _____
DVT/Phlebitis/Clots _____
Lupus _____

Cancer

Do you have any of the following **NO YES** if yes please indicate below

Type _____
Treatment _____
Location _____

Psychologic (Emotional)

Do you have any of the following **NO YES** if yes please indicate below

Nervousness _____
Anxiety _____
Depression _____
Other _____

Constitutional

Do you have any of the following **NO YES** if yes please indicate below

Fever _____
Chills _____
Weight Loss _____
Night Sweats _____