Surgical Group of South Laguna

A Medical Corporation

Name: ________________________________ male/female Age:________ Today's Date:____________
Last first middle

Occupation: ____________________________ Birthplace: __________________ Birth Date: ___________

Weight: Now ______ 1 year ago ______ Maximum _______

Please explain in detail your present problem. List dates.
1) ____
____
____

2) ____
____

List all medications taken in the last 6 months

Medication	**Dose**	**Date last taken**	**Medication**	**Dose**	**Date last taken**
For example, aspirin	*85 mg 2x day*	*6/5/04*			

Allergies

Have you ever had an allergic reaction to: (circle yes or no)					
Penicillin	yes	no	Iodine	yes	no
Sulfa	yes	no	Adhesive Tape	yes	no
Other antibiotics:			Latex	yes	no
Other:			Other:		

Tobacco and Alcohol: (circle all that apply)

Alcoholic beverages	Never	Rarely	Moderately	Daily
Tobacco: smoke | chew | cigars | cigarettes	Quantity:	Last used:		Never smoked

Medical History

Have you ever had: (circle yes or no, if yes give approximate date of onset and how long it lasted)					
Cancer: type:	yes	no	Arthritis	yes	no
Diabetes	yes	no	HIV/AIDS	yes	no
Heart Attack	yes	no	Blood Transfusion	yes	no
Congestive Heart Failure	yes	no	Tuberculosis	yes	no
Liver Problems	yes	no	Rheumatic Fever	yes	no
Coronary Artery Disease	yes	no	Other - type:	date:	
High Blood Pressure	yes	no	Other - type:	date:	
Bleeding Problem	yes	no	Other - type:	date:	
Surgical history (circle yes or no, if yes, give approximate date of surgery)					
Cancer surgery - type:				date:	
Appendectomy	yes	no	Heart bypass	yes	no
Tonsillectomy	yes	no	Heart valve replacement	yes	no
Cholecystectomy	yes	no	Other - type:	date:	
Hernia: type:	yes	no	Other - type:	date:	

Please complete Page 2

Signature: ___________________________

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Review of Systems

Do you now or have you ever had: (circle yes or no, if yes give approximate date of occurrence)					
EENT (Eyes, Ears, Nose and Throat)					
Eye disease injury or impaired sight	yes	no	Glasses	yes	no
Ear disease, injury or impaired hearing	yes	no	Hearing aid	R	L
Trouble with nose, sinuses, mouth, throat	yes	no	Dentures	yes	no
CNS (Central Nervous System)					
Loss of consciousness	yes	no	Convulsions	yes	no
Paralysis	yes	no	Frequent or severe headaches	yes	no
Endocrine					
Enlarged glands	yes	no	Enlarged Thyroid or goiter	yes	no
Skin disease	yes	no	Breast problems	yes	no
Cardio-Pulmonary					
Chronic or frequent cough	yes	no	Chest pain or angina pectoris	yes	no
Spitting up blood	yes	no	Heart attack	yes	no
Shortness of breath	yes	no	Palpitation or fluttering heart	yes	no
Swelling of feet and/or ankles	yes	no	Varicose veins	yes	no
Gastro-Intestinal					
Stomach trouble or ulcers	yes	no	Indigestion	yes	no
Liver or gallbladder disease	yes	no	Colitis or other bowel disease	yes	no
Hemorrhoids or rectal bleeding	yes	no	Change in appetite	yes	no
Change in bowel action or stool	yes	no	Do you take laxatives	yes	no
Genito-Urinary					
Prostrate Enlargement	yes	no	Kidney disease or Bladder disease	yes	no
Difficulty in urinating	yes	no	Arise at night to urinate	yes	no
Neuromuscular					
Stroke	yes	no	Weakness in arm or leg	yes	no
Muscle spasm or cramps in legs with walking	yes	no			

Family History

Has any family member ever had: (circle yes or no, if yes, enter who. For example, brother, mother, etc.)					
Breast Cancer	yes	no	Tuberculosis	yes	no
Colon Cancer	yes	no	Diabetes	yes	no
Other Cancer – type:	yes	no	Heart trouble	yes	no
High blood pressure	yes	no	Stroke	yes	no

Women Only

Menstrual/pregnancy History					
Age at first period:		Date of last period:			
Age of onset of menopause:		Age at 1st pregnancy:		How many pregnancies:	
Problems with periods or pregnancies:					

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Signature: ______________________________