# MEDICAL INFORMATION FORM

PATIENT NAME_____ DATE_____

AGE___ ☐ MALE ☐ FEMALE REFERED BY_____ PCP_____

HAS THE PATIENT PREVIOUSLY BEEN SEEN BY A DOCTOR AT SURGICAL ASSOCIATES?

YES__NO__ WHO_____M.D.

CHIEF COMPLAINT

1._____

2._____

3._____

PAST MEDICAL HISTORY AND SURGICAL HISTORY

OPERATIONS HOSPITAL & CITY DATE

1._____

2._____

3._____

4._____

HOSPITALIZATIONS

REASON HOSPITAL & CITY DATE

1._____

2._____

3._____

MEDICAL CONDITIONS FOR MEDICATIONS & ALLERGIES (please see other form)

Please mark all that apply. Give Date and Details when possible

| | | | | | |
|---|---|---|---|---|---|
| ☐ Heart Attack | Yes/No | ☐ Lung Disease/Asthma | Yes/No | ☐ GERD | Yes/No |
| ☐ Irregular heart rate | Yes/No | ☐ Prior Pneumonia | Yes/No | ☐ Prolonged Bleeding | Yes/No |
| ☐ Chest Pain (Angina) | Yes/No | ☐ Kidney Disease | Yes/No | ☐ Arthritis | Yes/No |
| ☐ High Blood Pressure | Yes/No | ☐ Intestinal/Rectal Bleeding | Yes/No | ☐ Seizures | Yes/No |
| ☐ Diabetes | Yes/No | ☐ Hepatitis/Jaundice | Yes/No | ☐ Alcoholism | Yes/No |

Other illnesses_____

Check if you have ever had any of the following

☐ COLONOSCOPY DATE_____ RESULTS_____ ☐ EGD DATE_____

☐ MAMMOGRAM DATE_____ RESULTS_____ RESULTS _____

PERSONAL HISTORY

Place of Birth_____

Children Yes/No Ages_____

Tobacco ☐ Never ☐ None No ☐ Yes Now How Long_____ How Many Per Day_____

Alcoholic Beverages ☐ Never ☐ Seldom ☐ Frequently Amount_____

Drug Abuse ☐ Never ☐ In the Past ☐ Now Types of drugs_____

FAMILY HISTORY

Please check if any blood relatives have had any of these

| | | | | | |
|---|---|---|---|---|---|
| ☐ Heart Disease | ☐ High Blood Pressure | ☐ Diabetes | ☐ Alcoholism | ☐ Asthma | ☐ Psychiatric Diseases |
| ☐ Blood Disease | ☐ Obscure Diseases | ☐ Breast Cancer | ☐ Colon Cancer | ☐ Ovarian Cancer | ☐ Lung Cancer |
| ☐ Esophageal Cancer | ☐ Gastric Cancer | ☐ Pancreatic Cancer | ☐ Thyroid Cancer | | |