Coastal Surgery Specialists

Patient History & Physical Form

Today's Date: ______________

NAME: ____________________________ **D.O.B:** ____________________ **AGE:** ________

Reason for today's visit: ____

Referring Physician: ____

Primary Care Physician: ____

Please list all **ALLERGIES & REACTIONS**: ____

Please list all **MEDICATIONS (including over the counter medication Ex: Vitamins, Aspirin, ect.)**

Medication	Dosage	Frequency

Social History

*(Please **X** all that apply)*

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Occupation:

Tobacco Use: [ ] Never [ ] Quit / When?: [ ] Current smoker/Packs per day:

Alcohol Use: [ ] Never/Quit When?: [ ] Rarely [ ] Moderate [ ] Daily/How many Drinks?:

Illicit Drug Use [ ] Never [ ] Quit/ When?: [ ] Type & Frequency:

PAST MEDICAL HISTORY

*(Please **X** all that apply)*

[ ] Abdominal Aortic Aneurysm (AAA)
[ ] AIDS
[ ] Alzheimer's Disease
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Asthma
[ ] Bleed easily / Clotting Disorder
[ ] Bronchitis
[ ] Cancer/Type: ____________________
[ ] Carotid Artery Disease (Neck Arteries)
[ ] Chronic Obstructive Pulmonary Disease
[ ] Congestive Heart Failure
[ ] Coronary Artery Disease
[ ] Deep Vein Thrombosis (DVT) / Blood Clot
[ ] Degenerative Disc Disease
[ ] Diabetes Mellitus [ ] Type I [ ] Type II
[ ] Emphysema
[ ] Epilepsy (fits, seizures, convulsions)
[ ] End Stage Renal Disease
[ ] Fibrocystic Breast Disease
[ ] Gastro esophageal Reflux Disease (GERD)
[ ] Heart Attack
[ ] Hemorrhoids
[ ] Hepatitis
[ ] Hernia Where? ____________________
[ ] Hiatal Hernia
[ ] HIV
[ ] High Cholesterol
[ ] High Blood Pressure
[ ] Irregular Heartbeat
[ ] Kidney Problems
[ ] Mental Illness/Type: ____________________
[ ] Migraine
[ ] Osteoporosis
[ ] Peripheral Vascular Disease
[ ] Phlebitis
[ ] PPD Positive
[ ] Pulmonary Embolus (blood clot in lung)
[ ] Rheumatic Fever
[ ] Sleep Apnea
[ ] Stroke / Ministrokes (TIA)
[ ] Thyroid Disease
[ ] Varicose Veins
[ ] No Significant Medical History
[ ] Other: ____________________
[ ] Other: ____________________
[ ] Other: ____________________

Name: ______________________________ **DOB:** ____________ **SC/06**

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PAST SURGICAL HISTORY

*(Please **X** all that apply and list approximate date)*

[ ] No Surgical History
[ ] AAA Repair: ____________
[ ] Abdominal Aortic Bypass: ____________
[ ] Amputation / Type?: ____________
[ ] Angiogram: ____________
[ ] Angioplasty / Stenting / Type: ____________
[ ] Appendectomy: ____________
[ ] Arteriogram: ____________
[ ] Bladder Surgery: ____________
[ ] Breast Surgery / Type: ____________
[ ] Bypass Graft Placed in legs: ____________
[ ] Right [ ] Left
[ ] Carotid Artery Surgery: ____________
[ ] Right [ ] Left
[ ] Colon Resection: ____________
[ ] Colonoscopy: ____________
[ ] Colostomy: ____________
[ ] C-Section: ____________
[ ] D and C: ____________
[ ] Dialysis Access /Permanent?: ____________

[ ] EGD / Upper Endoscopy: ____________
[ ] Gallbladder Removal: ____________
[ ] Heart Surgery / Type: ____________
[ ] Hysterectomy: ____________
[ ] Knee Surgery: ____________
[ ] Lung Surgery: ____________
[ ] Mastectomy: ____________
[ ] Nissen Fundoplication (GERD): ____________
[ ] Pacemaker Insertion: ____________
[ ] Port-O Catheter Placement: ____________
[ ] Splenectomy: ____________
[ ] Thyroidectomy: ____________
[ ] Partial: [ ] Rt [ ]Lft / [ ] Total
[ ] Tonsillectomy: ____________
[ ] Tubal Ligation / Vastectomy: ____________
[ ] Varicose Vein Surgery / Type?: ____________
[ ] Vascular Surgery / Type?: ____________
[ ] Other?: ____________
[ ] Other?: ____________
[ ] Other?: ____________

FAMILY MEDICAL HISTORY

*(Please **X** all that apply & what relative it applys to)*

[ ] Abdominal Aortic Aneurysm: ____________
[ ] Alcoholism: ____________
[ ] Anemia: ____________
[ ] Cancer / Type / Who? & Age of Onset:
____
____
[ ] Carotid Stenosis: ____________
[ ] Deep Vein Thrombosis (DVT): ____________
[ ] Family History of Arthritis: ____________
[ ] Family History of Diabetes: ____________
[ ] Family History of Stroke: ____________
[ ] Fibrocystic Breast Disease: ____________
[ ] Gallbladder Disease: ____________
[ ] Heart Attack: ____________

[ ] High Cholesterol: ____________
[ ] High Blood Pressure: ____________
[ ] Kidney Problems: ____________
[ ] Mental Illness: ____________
[ ] Obesity: ____________
[ ] Osteoarthritis: ____________
[ ] Osteoporosis: ____________
[ ] Peripheral Vascular Disease: ____________
[ ] Phlebitits: ____________
[ ] Thyroid disease: ____________
[ ] Varicose Veins: ____________
[ ] Venous in sufficiency: ____________
[ ] No Significant Family History
[ ] Other?: ____________

Name: ____________________ **DOB:** ____________ **SC/06**

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REVIEW OF SYSTEMS

(*Please **X** all that apply)*

Constitutional
[ ] Good General Health
[ ] Recent Weight Change
[ ] Night Sweats, Fevers
[ ] Fatigue

Ears/Nose/Mouth/Throat
[ ] Hearing Loss or Ringing
[ ] Sinus Problems
[ ] Nose Bleeds
[ ] Sore Throat / Voice Change

Eyes
[ ] Wear Glasses / Contacts
[ ] Blurred / Double Vision
[ ] Eye Disease or Injury
[ ] Glaucoma

Cardiovascular
[ ] Chest Pain
[ ] Palpitations
[ ] Heart Trouble
[ ] Swelling Hands / Feet

Respiratory
[ ] Shortness of Breath
[ ] Cough
[ ] Wheezing / Asthma
[ ] Coughing up Blood

Gastrointestinal
[ ] Nausea / Vomiting
[ ] Abdominal Pain
[ ] Rectal Bleeding
[ ] Bowel Problems

Musculoskeletal
[ ] Muscle Pain or Cramps
[ ] Stiffness / Swelling Joints
[ ] Joint Pain
[ ] Trouble Walking

Neurological
[ ] Frequent Headaches
[ ] Paralysis or Tremors
[ ] Convulsions / Seizures
[ ] Numbness / Tingling

Integumentary (Skin / Breast)
[ ] Change in Hair or Nails
[ ] Rashes or Itching
[ ] Breast Lump
[ ] Breast Pain or Discharge

Endocrine
[ ] Excessive Thirst / Urination
[ ] Thyroid Disease
[ ] Hormone Problem

Hematologic / Lymphatic
[ ] Bruise Easily
[ ] Slow to Heal
[ ] Enlarged Glands

Allergic / Immunologic
[ ] Food Allergies
[ ] Aspirin Allergies
[ ] Antibiotic Allergies

Psychiatric
[ ] Insomnia
[ ] Confusion
[ ] Memory Loss
[ ] Depression

Genitourinary
[ ] Blood in Urine
[ ] Kidney Stone
[ ] Sexual Problems
[ ] Male Only-Testicle Pain
[ ] Female Only-Menstrual Problems

Breast Patients Only

[ ] Past Hormone Replacements	Age of First Period: ________
[ ] Breast Implants	Age of Menopause: ________
[ ] Uterus Removed	Date of Last Period: ________
[ ] Ovaries Removed	Number of Pregnancies: ________
[ ] Past Oral Contraceptives	Number of Live Births: ________
[ ] Present Oral Contraceptives	Age at First Pregnancy: ________
[ ] Ashkenazi Jewish Descent	

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