Capital Health Surgical Group

Please provide the following confidential information regarding your medical history. Thank you.

NAME: _____ DOB: _____

***Reason for Appointment:** _____

***Referring Physician:** _____
Address: _____ Phone: _____

*Primary Care Physician: _____
Address: _____ Phone: _____

YOUR MEDICAL HISTORY:

		Name Dosage Strength Route
Do you take any medications?	YES NO ***LIST IF YES!!***	
Are you allergic to any medications?	YES NO ***LIST IF YES!!***	Reaction(s):
Are you allergic to **LATEX** or adhesives?	YES NO	Reaction:
Do you smoke or chew tobacco?	YES NO	How much per day? For how many years?
Do you drink alcohol?	YES NO	How much? How often?
Do you take aspirin or **any other blood thinners?**	YES NO	How much? How often?
Do you use non-prescription drugs?	YES NO	How much? How often?
Do you bleed or bruise easily?	YES NO	

Have you ever been hospitalized?	YES	NO	List:
Have you had any previous surgery?	YES	NO	List with dates:
Are you pregnant?	YES	NO	
Are there any illnesses that run in the family?	YES	NO	List:

Do you have any of the following medical problems? **If yes, please explain.**

Heart Disease	YES	NO	
High Blood Pressure	YES	NO	
Diabetes	YES	NO	
Thyroid problems:	YES	NO	
High cholesterol	YES	NO	
Rheumatic fever	YES	NO	
Heart murmurs	YES	NO	
Stomach problems: ***Explain**	YES	NO	
Liver problems or hepatitis	YES	NO	
Respiratory problems	YES	NO	
Arthritis	YES	NO	
Seizures or epilepsy	YES	NO	
Blood Disorders	YES	NO	
Cancer	YES	NO	
History of infection	YES	NO	List:
Other	YES	NO	

Do you have any of these following symptoms now? ***PLEASE CIRCLE ALL THAT APPLY***

Chills
Fatigue
Weight Loss
Anorexia
Night Sweats
Weight Gain
Obesity
Cancer of Head/Neck
Dizziness
Trouble Swallowing
Nose Bleeds
Headaches
Hoarseness/Voice Change
Bleeding Gums
Neck Mass
Oral Mass
Sleep apnea/obstruction
Stridor/Difficulty breathing
Shortness of Breath
Chest Pain
Arrythmias
Claudication
Palpitations
Syncope
Varicose veins

Apneic Events
Chest Tightness
Dyspnea
Wheezing
Abdominal Pain
Anorexia
Poor Appetite
Constipation
Diarrhea
Gas/Bloating
Acute Renal Failure
Anuria
Oliguria
Chronic Renal Failure
Pain on urination
Flank Pain
Blood in the urine
Hydrocele
Gout
Arthritic Joint Pain
Rheumatism
Muscle Weakness
Tingling
Cellulitis
Cyst

Ecchymosis
Folliculitis
Hydradenitis
Keloid
Skin Lesion
Telangiectasia
Aphasia
Abnormal Gait
Paresthesia
Seizure
Psychiatric Disorder
Adrenal Insufficiency
Hyperglycemia
Hypoglycemia
Post-Menopausal
Verilization
Bleeding Disorder
Lymphnode Enlargement/Mass
Prolonged PT/INR
Prolonged PTT
Pulmonary Embolus
Radiation Treatment
Venous Thrombosis
Allergies
Anaphylaxis

What is your present occupation? _____

I certify that the above information is complete and accurate.

Patient's signature: _____ Date: _____