Birmingham
SURGICAL, PC

DATE _____

PATIENT'S NAME _____ AGE _____ SEX _____
LAST FIRST M.I.

INFORMANT: _____ REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____ PH. #: _____

PHARMACY: _____ PH. #: _____

Medical Problems:

Circle yes or no:

Anxiety Disorder	Yes	No	Gall Bladder problems	Yes	No
Depression	Yes	No	Diverticulitis	Yes	No
Heart attacks	Yes	No	Liver cirrhosis	Yes	No
Coronary Artery Disease	Yes	No	Hepatitis B or C	Yes	No
Dyspnea on exertion	Yes	No	Cancer	Yes	No
Atrial fibrillation	Yes	No	Diabetes	Yes	No
Hypertension	Yes	No	Hypothyroidism	Yes	No
High Cholesterol	Yes	No	Hyperthyroidism	Yes	No
Deep Vein Thrombosis/clots in legs	Yes	No	Gout	Yes	No
Pulmonary Embolism	Yes	No	Arthritis	Yes	No
Pain in calves when walking/Claudication	Yes	No	Osteoporosis	Yes	No
COPD	Yes	No	Kidney Disease	Yes	No
Emphysema	Yes	No	Kidney Stones	Yes	No
Asthma	Yes	No	Bleeding problems	Yes	No
GERD/Reflux	Yes	No	Seizures	Yes	No
Ulcers in stomach/small intestine	Yes	No	Stroke	Yes	No

Other Medical Problems:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous Surgeries:

Surgical Procedure	Date	Hospital	Surgeon

Current Medications:

Allergies/intolerance to medications (list meds and reactions):

Family History (Specify Paternal or Maternal)

- Cancers: who, and what type? _____
- Bleeding problems? _____
- Diabetes? _____

Social History

- Do you use tobacco? **Yes** **No** What type? Cigarettes Cigars Chewing Tobacco
  How much? _____ How many years? _____
  If you quit in past, how long ago, and how much and how long did you smoke? _____
  _____
- Do you drink alcohol? **Yes** **No** How much and how often? _____
- Do you use any recreational drugs? **Yes** **No** If yes, what type? _____

REVIEW OF SYSTEMS

Please circle any/all conditions that you are currently experiencing

Constitutional: Fever, Night sweats, Weight gain:_____, Weight loss:_____, Exercise intolerance
(How much?) (How much?)

Eyes: Dry eyes, Irritation, Vision changes

ENMT: Difficulty hearing, Ear pain, Frequent nosebleeds, Nose/sinus problems, Sore throat, Bleeding gums, Enlargement below Adam's Apple, Swollen glands

Cardiovascular: Chest pain/pressure, Arm pain on exertion, Shortness of breath when walking, Shortness of breath when lying down, Palpitations, Known heart murmur

Respiratory: Cough, Wheezing, Shortness of breath, Coughing up blood, Sleep apnea

Gastrointestinal: Abdominal pain, Nausea , Vomiting, Vomiting blood, Poor appetite, Difficulty swallowing, Heartburn, Diarrhea, Constipation, Bright red blood with stools, Black/tarry stools, Anal pain, Pain with stools, Bowel urgency, Difficulty controlling gas, Difficulty controlling stools, cirrhosis, hepatitis

Genitourinary: Incontinence to urine, Difficulty urinating, Blood in urine

Musculoskeletal: Muscle aches, Muscle weakness, Joint pain, Back pain, Swelling in legs or arms

Integumentary: Abnormal moles, Yellow skin, New rashes

Neurologic: Loss of consciousness, Weakness, Numbness, Seizures, Dizziness, Head aches

Psychiatric: Depression, Sleep disturbance, Abuse of alcohol

Endocrine: Fatigue, Excessive thirst, Hair loss, Cold intolerance

Hematologic/Lymphatic: Swollen lymph nodes, Easy bruising, Excessive bleeding

Allergic/Immunologic: Sinus pressure, Runny nose, Itching, Hives

PHYSICIAN SIGNATURE: _____

DATE: _____