NAME _____

DOB_____ **TODAY'S DATE** _____

PRINCETON SURGICAL ASSOCIATES, P.A.

An accurate history is important for us to give you the best treatment recommendations as possible.
Please complete both sides of this form.

Why are you here?

_____

_____

Prior Surgery (Type/Year/Surgeon)

_____

_____

_____

_____

_____

_____

Last Colonoscopy: _____

Last Sigmoidoscopy: _____

Medical Problems (circle or add diseases)

Diabetes	Hypertension	Prostate
Asthma	Heart Disease	MVP
Hepatitis	High Cholesterol	COPD
Atrial Fib	Gastrointestinal	Stroke
Ulcers	Heart Attack	Thyroid
Polyps	Valve/Joint Replacement	
Kidney	Glaucoma	

Cancer (type) _____

Other: _____

Prior Chemotherapy?_____

Prior Radiation? _____

Family Medical History

_____

_____

_____

_____

Habits:

Smoking? Never ____ Former____ Current____

Alcohol? Never Daily Weekly Rarely

Caffeine? _____ Cups/Day? _____

Exercise? _____ Type _____

Do you have a living will? _____

Referring Doctor:

_____

Primary Doctor:

_____

Operations (circle):

Gallbladder, appendix, hysterectomy, breast, vascular, hernia, C-section, hemorrhoids, tonsils, orthopedic, D & C, cancer surgery, heart, colon, pacemaker/defibrillation unit.

Medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

Do you take any blood thinners of any kind?
(Including Aspirin or Plavix) YES NO

Allergies to medicines (reaction type?)

_____

_____

_____

Latex allergy? _____

OB/GYN History:

Number of Pregnancies: _____

Number of Children: _____

Last Mammogram: _____

Last Menstrual Period: _____

Your Pharmacy: _____

Pharmacy Phone #:_____

PLEASE COMPLETE REVERSE SIDE

REVIEW OF SYSTEMS **NAME: _____DOB: _____**

TO BE COMPLETED BY PATIENT

CONSTITUTIONAL SYMPTOMS

Good general health lately ……..	No	Yes
Recent weight change ……	No	Yes
Fever……..	No	Yes
Fatigue……	No	Yes
Headaches ……..	No	Yes

Eyes

Eye disease or injury ……..	No	Yes
Wear glasses/contact lenses …… .	No	Yes
Blurred or double vision ……..	No	Yes
Glaucoma……..	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss……..	No	Yes
Ringing in Ears ……..	No	Yes
Earaches or drainage……..	No	Yes
Chronic sinus problems or rhinitis ….....	No	Yes
Nose bleeds ……..	No	Yes
Mouth sores ……..	No	Yes
Bleeding gums ……..	No	Yes
Bad breath or bad taste ……	No	Yes
Sore throat or voice change ……..	No	Yes
Swollen glands in neck ……..	No	Yes

CARDIOVASCULAR

Heart trouble …… ……..	No	Yes
Chest pain or angina pectoris ……..	No	Yes
Palpitation……..	No	Yes
Shortness of breath with exertion…… ….	No	Yes
Swelling of feet, ankles, or hands …….	No	Yes

RESPIRATORY

Chronic or frequent coughs ……..	No	Yes
Spitting up blood …….. …	No	Yes
Shortness of breath …….. …	No	Yes
Asthma or wheezing ……..	No	Yes

GASTROINTESTINAL

Loss of appetite…… …….	No	Yes
Change in bowel movements ……..	No	Yes
Nausea or vomiting ……..	No	Yes
Frequent diarrhea …… ……..	No	Yes
Painful bowel movements/constipation....	No	Yes
Rectal bleeding or blood in stool …….	No	Yes
Abdominal pain …… …….	No	Yes

GENITOURINARY

Frequent urination ……..	No	Yes
Burning or painful urination ……..	No	Yes
Blood in urine ……..	No	Yes
Change in force of stream when urinating.	No	Yes
Incontinence or dribbling ……..	No	Yes
Kidney stones ……..	No	Yes
Sexual difficulty ……..	No	Yes
Male-testicle pain ……..	No	Yes
Female-periods: pain/irregular (circle).....	No	Yes
Female-vaginal discharge ……..	No	Yes

MUSCULOSKELETAL

Joint pain ……..	No	Yes
Joint stiffness and swelling ……..	No	Yes
Weakness of muscles or joints….. .	No	Yes
Muscle pain or cramps ……..	No	Yes
Back pain ……..	No	Yes
Cold extremities ……..	No	Yes
Difficulty in walking ……..	No	Yes

INTEGUMENTARY (SKIN, BREAST)

Rash or itching ……..	No	Yes
Change in skin color ……..	No	Yes
Change in hair or nails ……..	No	Yes
Varicose veins ……..	No	Yes
Breast pain ……..	No	Yes
Breast lump……..	No	Yes
Breast discharge ……..	No	Yes

NEUROLOGICAL

Light headed or dizzy ……..	No	Yes
Convulsions or seizures ……..	No	Yes
Numbness or tingling sensations ……	No	Yes
Tremors……..	No	Yes
Paralysis…….. ……..	No	Yes
Stroke ……..	No	Yes
Head injury ……..	No	Yes

PSYCHIATRIC

Memory loss or confusion ……..	No	Yes
Nervousness ……..	No	Yes
Depression ……..	No	Yes
Insomnia ……..	No	Yes

ENDOCRINE

Glandular or hormone problem ……..	No	Yes
Thyroid disease ……..	No	Yes
Diabetes -circle one (insulin or non-insulin)	No	Yes
Excessive thirst or urination ……..	No	Yes
Heat or cold intolerance ……..	No	Yes
Skin becoming dryer ……..	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal cuts; bruising ……..	No	Yes
Anemia ……..	No	Yes
Phlebitis ……..	No	Yes
Past transfusion ……..	No	Yes
Enlarged glands ……..	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics ……..	No	Yes
Morphine, Demerol, or other narcotics…..	No	Yes
Novocain, Lidocaine or other anesthetics…	No	Yes
Aspirin or other pain remedies ……..	No	Yes
Iodine, merthiolate or other antiseptic ……	No	Yes

Known food or other allergies: _____

Physician Signature: _____ **Date:** _____