PRINCETON SURGICAL ASSOCIATES **Dr. Davidov's Patient Questionnaire**

Name: _____ **DOB**: _____ **Age:** _____ **Date:**_____

How can we help you:
□ gallbladder □ hernia □ colon □ thyroid □ parathyroid
□ other: _____

Primary MD: _____
Referring MD or friend: _____
Cardiologist (if have): _____

Past Medical History:

- □ High Blood Pressure
- □ High Cholesterol
- □ Diabetes – taking insulin
- □ Diabetes – no insulin
- □ Asthma – on daily inhaler
- □ Asthma – rarely use inhaler
- □ Heart attack – no stent
- □ Heart attack – with stent
- □ Heart attack – w/ heart surgery
- □ Cardiac arrest
- □ Congestive heart failure
- □ Heart block/ pacemaker
- □ Atrial fibrillation
- □ Deep Vein Thrombosis (DVT)
- □ Pulmonary Embolism (PE)
- □ COPD or emphysema
- □ Sleep apnea
- □ Stroke
- □ Seizure
- □ Kidney problems – on dialysis
- □ Kidney problems – no dialysis
- □ Anesthesia complications
- □ Lupus or autoimmune disorder
- □ Bleeding disorder: _____
- □ Breast Cancer
- □ Lung Cancer
- □ Prostate Cancer
- □ Colon Cancer
- □ Other Cancer: _____
- □ Diverticulitis
- □ Gastrointestinal bleeding
- □ Gastritis or stomach ulcer
- □ Crohn's Disease or Ulcerative Colitis
- □ Hepatitis B
- □ Hepatitis C
- □ Cirrhosis
- □ HIV
- □ Hypothyroidism
- □ Hyperthyroidism
- □ Kidney Stones
- □ Osteoporosis
- □ Peripheral vascular disease
- □ Substance abuse
- □ Other: _____

Prior Operations:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Social History:
Do you smoke now? ____ In the past? ____
How much? _____ Year quit? _____
How often do you drink alcohol? _____
Are you recovering from any addiction? ___
What kind of work do you do?

Review of Systems:

- □ Fever
- □ Night sweats
- □ Weight loss
- □ Blurry vision
- □ Yellowing of eyes
- □ Chronic cough
- □ Chronic nose bleed
- □ Swollen lymph nodes
- □ Neck pain
- □ Neck pressure
- □ Neck fullness
- □ Difficulty swallowing
- □ Choking sensation
- □ Hoarse voice
- □ Chest pain
- □ palpitations
- □ Swollen ankles
- □ Shortness of breath
- □ Wheezing
- □ Chronic cough
- □ Shirt collar size 17+
- □ Chronic nausea
- □ Chronic diarrhea
- □ Constipation
- □ Blood in stool
- □ Dark or tarry stool
- □ Light-colored stool
- □ Heartburn
- □ Hospitalization for intestinal blockage
- □ Hospitalization for diverticulitis
- □ Difficulty urinating
- □ Waking up more than once at night to urinate
- □ Continence problems
- □ Chronic back pain
- □ Chronic groin pain
- □ Chronic hip pain
- □ Difficulty walking
- □ Rash
- □ Yellowing of skin
- □ Latex allergy
- □ Frequent headache
- □ Arm or leg numbness
- □ Arm or leg weakness
- □ Depression
- □ Anxiety
- □ Brain fog
- □ Insomnia
- □ Cold intolerance
- □ Heat intolerance
- □ Profound fatigue
- □ Hair loss
- □ Radiation exposure
- □ Easy bruising
- □ Religious objection to blood transfusion
- □ Last colonoscopy: ___
- □ Upper endoscopy: ___

Family History:

- □ Diabetes
- □ High Blood Pressure
- □ High Cholesterol
- □ Heart Disease
- □ Asthma
- □ Bleeding problems
- □ Breast Cancer
- □ Colon Cancer
- □ Thyroid Cancer
- □ Thyroid problems
- □ Parathyroid problems
- □ Lymphoma/ leukemia

Patient Signature: _____ Physician Signature: _____

PLEASE COMPLETE REVERSE SIDE

Patient Name: _____

Date: _____

Current medications:

Drug name	Dosage	How often taken

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies (what is the reaction - e.g. hives, rash, face swelling)

_____