

DEKALB SURGICAL ASSOCIATES PATIENT QUESTIONNAIRE

Name _____ Age _____ Today's Date _____

Your Primary Physician _____ Office Phone _____ Did they refer you? Y or N

If no, which physician referred you to us? _____ Office Phone _____

Reason for your visit: _____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH MAY APPLY TO YOU

High blood pressure Prior heart attack Heart failure Chronic lung disease Diabetes on pills on Insulin

General: Your weight? _____ Unintended weight loss or gain, fatigue, fevers / chills, sweats, heat intolerance, insomnia

Eyes: Loss of vision, cataracts, cataract surgery, glaucoma, intolerance of bright lights

Cardiovascular: High cholesterol, angina / chest pain, bypass surgery / angioplasty, irregular heartbeat / palpitations, poor circulation

Respiratory: Emphysema, asthma, sleep apnea, shortness of breath, chronic cough, hoarseness

Gastrointestinal: Ulcers, acid reflux / heartburn, nausea, vomiting, gallstones, constipation, diarrhea, blood in stool, abdominal pain chronic acute/recent, difficulty swallowing, hepatitis, cirrhosis, date of last colonoscopy _____

Urinary: Kidney failure/ dialysis, kidney stones, burning or blood in urine, urinary infections in the past, last PSA date _____

Musculoskeletal: Arthritis in knees hips hands _____, hip knee replacement, gout, osteoporosis

Breast/ Gyn: Previous biopsies, breast lump, abnormal mammogram, breast pain, last mammogram date _____

Vaginal bleeding / discharge, Pelvic pain Last period, or date of menopause _____, Last Pap date _____

Skin: Previous skin cancers, melanoma, recent change in a mole, eczema, psoriasis

Neurologic: Epilepsy / seizure disorder, stroke (year _____), headaches, numbness, weakness, dizziness, jaw pain

Psychiatric: Schizophrenia, depression, anxiety, irritability, other mental illness

Hematologic: Blood clots, deep vein thromboses (DVT), varicose veins, anemia, easy bruising / bleeding, on Coumadin, +HIV

Endocrine: Overactive or underactive thyroid, thyroid mass, on Prednisone or other steroid

Cancer Survivor: Lung, breast, colon, prostate, ovarian, other _____ Yr of diagnosis: _____

Do you: Smoke? Not since _____ No 1/2 1 2 pks/day, **Drink alcohol?** None 1-2 drinks/day > 2/day

Do you: Use any recreational drugs? Yes No Exercise regularly? Yes No

Family history: Father Alive Deceased Medical problems _____

Mother Alive Deceased Medical problems _____

How many Brothers _____ Sisters?_____ Family members with: High blood pressure, heart disease, diabetes, cancer

Please provide additional information on any circled items or other medical problems: _____

Previous surgeries with dates : _____

Allergies: Penicillin, iodine dye, aspirin, codeine, sulfa, latex rubber, other _____

Medications (including nonprescription medications, please provide dosage and frequency if known): _____

Vital Signs (nurse will complete) T _____ BP _____ P _____

Patient Signature

Physician signature Date

I understand that the above medical information will be used in making treatment decisions and I attest that it is accurate to the best of my knowledge.

I have reviewed the above medical information with the patient.