ADVANCED SURGEONS, P.C.
LEADING-EDGE, FAITH-BASED CARE

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(205) 595-8985
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I. PERSONAL DATA

Name: ______________________ Date: __________ Age: __________

Referring Physician: ______________________ Regular Physician: ______________________

Have you or your family been patients of Advanced Surgeons P.C. before: Yes No

If "Yes" then: Who was the patient: ______________________ Relationship: ______________________

II. PRESENT ILLNESS

Reason for visit: ______________________ Date of onset: __________

Describe problem:

III. CURRENT MEDICATIONS

Please list current medications you are taking and their dosage
ATTENTION: PLEASE NOTE IF YOU ARE ON COUMADIN, ASPIRIN OR PREDNISONE

Medication	Daily Dosage	Medication	Daily Dosage

IV. ALLERGIES TO MEDICATIONS

List medicine and reactions experienced (for ex. Penicillin = Rash, or Codeine = Nausea & vomiting)

Medication	rash	nausea	vomiting	other

V. FAMILY HISTORY

Do you have a family history of the following? If yes, what relation to you?

	Relation
Bleeding problems	
Blood Clots/phlebitis	
Cancer (type or organ)	
Other:	

VI. SOCIAL HISTORY

Occupation: ______________________ Spouse Occupation: ______________________

Church Attendance: YES NO Denomination: __________

Do you smoke? YES NO If "Yes" how many per day? ______ How many years? __________

Do you consume alcohol? YES NO If "Yes" how frequent __________ How much? __________

VII. MEDICAL HISTORY

Do you have or have you ever been diagnosed with any of the following medical conditions? Please check and supply year of occurrence or onset.

	CONDITION	YEAR		CONDITION	YEAR
	Anemia			High Blood Pressure	
	Arthritis			High Cholesterol	
	Asthma			HIV Disease	
	Bleeding Problems			Irregular Heart Beat	
	Blood clots/phlebitis			Irritable Bowel Disease	
	Cancer:			Kidney Failure	

VII. MEDICAL HISTORY – continued

	Type:	Organ:			
	Chronic Lung Disease			Kidney Stones	
	Colitis			Mental Illness.Depression	
	Colon Polyps			Migraine Headaches	
	Diabetes oral meds insulin			Mitral Valve Prolapse/Antibiotics	
	Diverticulitis			Prostate Disease	
	Drug Dependency			Recurrent Bronchitis	
	Emphysema			Seizures	
	Heart Attack/Heart Disease			Sleep Apnea	
	Heart Failure			Stroke	
	Hepatitis			Thyroid Condition	
	Hiatal Hernia/Reflux			Tuberculosis	
				Ulcer Disease stomach duodenal	
	Other:				

VIII. PREVIOUS SURGERIES

Please check types of surgery you have had. Write in approximate year surgery was performed.

	SURGERY	YEAR		SURGERY	YEAR
	Appendix			Hernia	
	Back (disc or fusion)			Hysterectomy	
	Blood Vessels			Joint (replacement or repair)	
	Bone Repair			Kidney	
	Bowel/Intestinal			Liver	
	Brain			Lung	
	Breast			Ovary/Tube	
	C-section			Prostate/Bladder	
	Eye			Thyroids	
	Gallbladder			Tonsils/Adenoids	
	Heart			Trauma	
	Hemorrhoid			Wisdom Tooth Extraction	
	Other surgery:				

IX. REVIEW OF SYSTEMS

Do you have any of the following? Check all that apply.

EYES:	loss of vision	blurred vision	changes	
EARS:	drainage	hearing loss	dizziness	ringing
NOSE:	nose bleed	sinus drainage		
THROAT:	hoarseness	trouble swallowing	sore throat	lump in neck
LUNGS:	wheezing	productive cough	shortness of breath	coughing up blood
HEART:	chest pain with exertion		heart racing	irregular heart beat
	swelling in legs	smothering at night	circulation problems	
GI:	stomach pain	nausea	vomiting	diarrhea
	blood in bowel movement		change in bowel habits	
GU:	pain or burning on urination		difficulty urinating	blood in urine
GYN:	abnormal vaginal discharge or bleeding		irregular periods	currently pregnant
SKIN:	recent rash	skin lesion that is growing or changing		
NEURO:	numbness or weakness of body parts		convulsions	memory loss
	anxiety attacks	tremors	depression or psychological condition	
OTHER:	weight loss	sweats	decreased appetite	fever

X. PHYSICAL EXAM

Blood Pressure ______________________ Temperature ____________________

Pulse Rate ______________________ Weight ____________________

Respiration ______________________ Height ____________________