

**REGIONAL SURGICAL SPECIALISTS, INC.**

GENERAL • ENDOSCOPIC • LAPAROSCOPIC • VASCULAR

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**PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:**

**PATIENT'S NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
FIRST MIDDLE LAST

**FAMILY DOCTOR:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PROBLEM:** \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES?** *Please check Yes or No*

- |  |  |
|--|--|
| DIABETES ..... <input type="radio"/> Yes <input type="radio"/> No        | ARTHRITIS..... <input type="radio"/> Yes <input type="radio"/> No            |
| HEART DISEASE..... <input type="radio"/> Yes <input type="radio"/> No    | HIGH CHOLESTEROL..... <input type="radio"/> Yes <input type="radio"/> No     |
| SEIZURES ..... <input type="radio"/> Yes <input type="radio"/> No        | KIDNEY DESEASE..... <input type="radio"/> Yes <input type="radio"/> No       |
| THYROID DISEASE ..... <input type="radio"/> Yes <input type="radio"/> No | HIGH BLOOD PRESSURE ..... <input type="radio"/> Yes <input type="radio"/> No |
| STROKE ..... <input type="radio"/> Yes <input type="radio"/> No          | BLEEDING TENDENCIES ..... <input type="radio"/> Yes <input type="radio"/> No |
| LUNG DISEASE ..... <input type="radio"/> Yes <input type="radio"/> No    | CANCER..... <input type="radio"/> Yes <input type="radio"/> No               |

*Type* \_\_\_\_\_

**PLEASE LIST PREVIOUS SURGERIES — WHEN?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICATIONS:	DOSAGE (MG):	HOW OFTEN PER DAY?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ARE YOU TAKING ASPRIN OR OTHER BLOOD THINNERS (Coumadin/Warfarin)?**  Yes  No

**ALLERGIES:** \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HABITS:**     **HEIGHT:**\_\_\_\_\_ **WEIGHT:**\_\_\_\_\_

**USE OF TOBACCO:**  NEVER  CURRENT (*Number of Packs Per Day*) \_\_\_\_\_  QUIT / **DATE:**\_\_\_\_\_

**USE OF ALCOHOL:**  NEVER  OCCASIONALLY  DAILY

**FAMILY HISTORY: DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING:**

- |                                    |   |   |  |
|------------------------------------|---|---|--|
| <input type="radio"/> DIABETES     | <input type="radio"/> STROKE              | <input type="radio"/> KIDNEY DISEASE      | <input type="radio"/> HEART DISEASE    |
| <input type="radio"/> LUNG DISEASE | <input type="radio"/> HIGH BLOOD PRESSURE | <input type="radio"/> BLEEDING TENDENCIES | <input type="radio"/> SEIZURE DISORDER |

CANCER     *Type/Who:* \_\_\_\_\_

**ARE YOU EXPERIENCING ANY OF THE FOLLOWING?**

**CONSTITUTIONAL**

- Fever .....  Yes  No
- Fatigue .....  Yes  No
- Recent Weight Change .....  Yes  No
- Insomnia.....  Yes  No
- Stress.....  Yes  No

**EYES**

- Wear Glasses / Contacts .....  Yes  No
- Eye / Vision Problems .....  Yes  No

**EARS, NOSE, MOUTH, THROAT**

- Ear Aches .....  Yes  No
- Hearing Loss / Ringing .....  Yes  No
- Nose Bleeds .....  Yes  No
- Sinus Problems .....  Yes  No
- Frequent Colds .....  Yes  No
- Dental Problems.....  Yes  No
- Sore Throat / Hoarseness .....  Yes  No

**CARDIOVASCULAR**

- Chest Pain.....  Yes  No
- Irregular / Fast Heartbeat .....  Yes  No
- Cold Extremities.....  Yes  No
- Numbness / Weakness - Arms / Legs...  Yes  No
- Varicose Veins / Phlebitis .....  Yes  No
- Swelling of Feet / Ankles.....  Yes  No
- Pain When Walking.....  Yes  No

**RESPIRATORY**

- Coughs .....  Yes  No
- Shortness of Breath .....  Yes  No
- Spitting Up Blood .....  Yes  No
- Asthma / Wheezing.....  Yes  No

**GASTROINTESTINAL**

- Loss of Appetite .....  Yes  No
- Nausea / Vomiting.....  Yes  No
- Diarrhea .....  Yes  No
- Constipation .....  Yes  No
- Change in Bowels.....  Yes  No

**HEMATOLOGICAL / LYMPHATIC**

- Slow to Heal After Cuts.....  Yes  No
- Anemia .....  Yes  No
- Blood Transfusions.....  Yes  No
- Bleeding / Bruising .....  Yes  No
- Swollen Glands.....  Yes  No

**ALLERGY / IMMUNOLOGIC**

- Allergies .....  Yes  No
- Hepatitis .....  Yes  No
- HIV / AIDS.....  Yes  No

**MUSCULOSKELETAL**

- Joint Pain / Swelling .....  Yes  No
- Muscle Joint Weakness.....  Yes  No
- Back Pain .....  Yes  No

**NEUROLOGICAL**

- Frequent Headaches.....  Yes  No
- Light Headed / Dizzy .....  Yes  No
- Seizures.....  Yes  No
- Paralysis .....  Yes  No
- Change in Speech .....  Yes  No

**PSYCHIATRIC**

- Memory Loss / Confusion .....  Yes  No
- Nervousness / Depression .....  Yes  No

**ENDOCRINE**

- Hormone Problem.....  Yes  No
- Excessive Thirst or Urination .....  Yes  No
- Heat / Cold Intolerance .....  Yes  No

**INTEGUMENTARY / BREAST**

- Rash / Itching .....  Yes  No
- Change in Skin / Hair / Nails .....  Yes  No
- Yellow Jaundice .....  Yes  No
- Breast Pain .....  Yes  No
- Breast Lump.....  Yes  No
- Nipple Discharge / Bleeding .....  Yes  No

**GENITOURINARY**

- Frequent Urination.....  Yes  No
- Painful / Burning Urination .....  Yes  No
- Bladder Control Problem.....  Yes  No
- Kidney Stones .....  Yes  No
- Change in Force or Stream .....  Yes  No
- Venereal Disease.....  Yes  No

**WOMEN (ONLY)**

- Last Menstrual Period:..... \_\_\_\_\_
- How Many Pregnancies?..... \_\_\_\_\_
- How Many Full Term? ..... \_\_\_\_\_
- How Many Miscarriages? ..... \_\_\_\_\_
- Age at First Menstrual Period:..... \_\_\_\_\_
- Age at First Pregnancy: ..... \_\_\_\_\_
- Did You Breast Feed?  Yes  No

**MALES (ONLY)**

- Testicle Pain  Yes  No
- Prostate Problems  Yes  No

**Signature** \_\_\_\_\_