NORTH SPRINGS SURGICAL ASSOCIATES
Medical History Sheet

Name: _____ **Referring Physician:** _____ **Primary Care Physician:** _____

Age: ____ **DOB:** ___-___-___ **Height:** _____ **Weight:** _____

Chief Complaint: Why are you coming to the office?

_____

Family History (grandparents, parents, siblings) **of chronic or related illnesses** (person and problem):_____

_____

Year	SURGICAL History
____	_____
____	_____
____	_____
____	_____
____	_____
____	_____

DRUG ALLERGIES or sensitivities to medications, tape, dyes, iodine, foods and reaction:

_____
_____
_____
_____

MEDICATIONS: List prescriptions, inhalers, over the counter drugs, vitamins, herbs, recreational drugs and supplements:

Name	Dose/Freq
☐ **check box if list attached**	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CHRONIC MEDICAL PROBLEMS. Please write YES/NO in the space below and circle problem:

1.Headache_____ **15.Blood clots/DVT/Pulmonary Embolus**_____
2.Fainting/Dizziness_____ **16.Anemia/Sickle Cell Disease**_____
3.Head/Neck/Back Injury_____ **17.Arthritis/Joint Swelling**_____
4.Stroke/TIAs_____ **18.Ulcers/Heartburn/GERD**_____
5.Epilepsy/Seizures_____ **19.Hepatitis/Cirrhosis/Liver Disease**_____
6.Mental Illness/Depression/Anxiety_____ **20.HIV+/AIDS**_____
7.Heart Valve Problems/Rheumatic Fever_____ **21.Kidney Disease/Kidney Stones**_____
8.Angina/Chest Pains/Heart Attack_____ **22.Bowel/Bladder Problems**_____
9.Other Heart Problems/Pacemaker_____ **23.Diabetes**_____
10.Low/High Blood Pressure_____ **24.Thyroid Disease**_____
11.Shortness of Breath/CHF_____ **25.Cancer**_____
12.Lung Problems/Asthma_____ **26.Could you be pregnant?**_____
13.Smoker?___ **Packs/Day:**___ **#yrs**__ **Quit?**___ **27.Alcohol?**___ **#drinks/day**_____
14.Tuberculosis_____ **28.Anesthesia Problems**_____
Other_____

If you marked "Yes," please write the number and comment:_____
_____
_____
_____

Signature of person filling out form:_____ **Relationship**:_____

For Physician's Use Only

PE: Vitals: HR___ RR___ Temp____ BMI_____
A&Ox3 in NAD_____*(other___)*
-Neck: Soft/supple_____*(other___)*
Thyroid: no masses___*(other___)*
-Chest: CTA_____*(other___)*
Effort nl/no accessory muscles___*(other___)*
-CV: RRR_____*(other___)*
Ext: No edema_____*(other___)*
-Psych: A&Ox3_____*(other___)*
Affect pleasant/nl_____*(other_____)*

Reviewed by: *Physician/Date:* _____