Chesapeake
SURGICAL ASSOCIATES

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PLEASE PRINT

Demographics

Patient Name: _____ Email: _____

Sex: Male Female DOB: _____

Language: _____ Race: _____ Ethnicity: _____ (Required by CMS)

Primary Care Physician: _____

Referring Physician: _____

Pharmacy Name & Phone Number: _____

Medications

Allergies to Medications & Reactions: _____

Current Medications & Dosage: _____

_____

_____

Past Medical History (have you ever had the following problems: *Circle Yes or No*)

Anxiety	Yes	No	High Cholesterol	Yes	No
Arthritis	Yes	No	Hypertension	Yes	No
Asthma	Yes	No	Hyperthyroidism	Yes	No
Bleeding Problems	Yes	No	Hypothyroidism	Yes	No
Blood Transfusion	Yes	No	Irritable Bowel	Yes	No
COPD	Yes	No	Kidney Disease	Yes	No
Cancer	Yes	No	Kidney Stones	Yes	No
CAD	Yes	No	Liver Disease	Yes	No
Depression	Yes	No	Osteoporosis	Yes	No
Diabetes	Yes	No	Pulmonary Embolism	Yes	No
Diverticulosis	Yes	No	Radiation Exposure	Yes	No
Fibromyalgia	Yes	No	Reaction to anesthesia	Yes	No
GERD/Reflux	Yes	No	Seizures	Yes	No
Gout	Yes	No	Sleep Apnea	Yes	No
HIV/AIDS	Yes	No	Stomach Ulcers	Yes	No
Heart Disease	Yes	No	Stroke	Yes	No
Hepatitis B	Yes	No	Tuberculosis	Yes	No
Hepatitis C	Yes	No			

Family History Do any of your immediate family members (blood relatives) suffer from: (specify relationship & maternal/paternal)

Diabetes	Yes	No	_____	Cancer, Breast	Yes	No	_____	Irritable Bowel	Yes	No	_____
Seizures	Yes	No	_____	Cancer, Ovarian	Yes	No	_____	Gallstones	Yes	No	_____
Hypertension	Yes	No	_____	Cancer, Colon	Yes	No	_____	Stomach Ulcers	Yes	No	_____
Heart Disease	Yes	No	_____	Cancer, Other	Yes	No	_____	Other:	Yes	No	_____

Social History

Occupation _____ Marital Status _____

Smoking Status: (Circle One) Never Smoked Former Smoker Current Smoker Unknown

If yes how much? _____ Smoked since age? _____

Alcohol Use: (Circle One) Occasional Moderate Heavy None

Caffeine Use: (Circle One) Occasional Moderate Heavy None

Advance Directives: Yes No Work Related: Yes No

Surgical History Please list hospitalizations and surgical procedures

_____

_____

Review of Systems

Patient Name: _____ Date: _____

Are you experiencing any of these symptoms? Circle Yes or No.

Fever	Yes	No
Weight Gain	Yes	No
Exercise Intolerance	Yes	No
Night Sweats	Yes	No
Weight Loss	Yes	No
Vision Changes	Yes	No
Difficulty Hearing	Yes	No
Frequent Nosebleeds	Yes	No
Sore Throat	Yes	No
Ear pain	Yes	No
Nose/Sinus Issues	Yes	No
Dry Mouth	Yes	No
Chest Pain	Yes	No
Palpitations	Yes	No
Heart Murmur	Yes	No
Shortness of Breath When Walking	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Normal Appetite	Yes	No
Vomiting Blood	Yes	No
Black/Tarry Stools	Yes	No
Incontinence	Yes	No
Hematuria (Blood in Urine)	Yes	No
Difficulty Urinating	Yes	No
Increased Frequency	Yes	No
Incomplete Emptying	Yes	No

Muscle Aches	Yes	No
Arthralgia/Joint Pain	Yes	No
Swelling in the Extremities	Yes	No
Muscle Weakness	Yes	No
Back Pain	Yes	No
Rash	Yes	No
Keloids	Yes	No
Itching	Yes	No
Loss of Consciousness	Yes	No
Numbness	Yes	No
Dizziness	Yes	No
Weakness	Yes	No
Seizures	Yes	No
Migranes	Yes	No
Depression	Yes	No
Sleep Disturbances	Yes	No
Fatigue	Yes	No
Swollen Glands	Yes	No
Excessive Bleeding	Yes	No
Bruise Easily	Yes	No
Runny Nose	Yes	No
Hives	Yes	No
Sinus Pressure	Yes	No

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