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Surgical Associates of Gadsden

Medical History

Date: _____

Name *(please print)*	Reason for today's visit
Referring Physician	Primary Care Physician *(if different from referring)*

Please Check All that apply

General:
__ Weakness or Fatigue
__ Recent Weight change
__ Fever
__ Smoker
__ Consume alcoholic beverages

Head, ears, eyes, nose, mouth, throat:
__ Frequent nose bleeds
__ Swollen glands
__ Difficulty swallowing

Cardiovascular:
__ High blood pressure
__ Abnormal heart beat-skipped or extra beats
__ Enlarged heart, abnormal heart or heart failure
__ Treated for chest pain or heart attack

Respiratory:
__ Severe shortness of breath
__ Coughing up blood
__ Asthma

Gastrointestinal:
__ Recurrent indigestion or heartburn
__ Major changes in bowel movements-size, frequency, stool appearance, etc.
__ Rectal bleeding
__ Nausea or vomiting
__ Chronic intestinal problems
__ Abdominal Pain
Location of Pain: __Left __Right __Upper __Lower
__Intermittent __Chronic
__Burning __Dull
__Sharp __Stabbing

Musculoskeletal:
__ Walking or balancing difficulties
__ Frequent muscle cramps

Brest:
__ Nipple discharge or discoloration
__ Breast mass or lumps
__ Extrreme breast tenderness
__ History of breast infection or injury

FEMALES ONLY:
__Pregnant Date of last period_____
Do you have any children? Y or N
If yes how many?_____

Skin:
__ History of skin cancer: type?/ Location?
_____
__ Change in mole or birth mark: location?
_____

Neurological:
__ Seizures
__ Fainting or blackouts

Endocrine:
__ Thyroid problems
__ Diabetes

Hematologic/ Lymphatic:
__ Anemia/ low blood count
__ Blood clots
__ History of chronic infections/ swollen lymph nodes

Allergic/Immunoligic:
__ HIV +
__ Tuberculosis/ positive skin test Cancer:
__ Hepatitis

Cancer:
__Cancer: Type?/Location?
_____
_____

ALL PAST SURGERIES:
_____
_____
_____