Elite Surgery Center

Patient's Name: ______________________________

DOB: ______________________________

ADULT MEDICAL HISTORY FORM

1. PRESENT ILLNESS AND DURATION:

2. SCHEDULED SURGERY:

3. DATE OF SURGERY:

4. If you are now under regular medical care, list reason and duration:

Primary Care Physician: ____________________

Office Location: ____________________

5. Height _______ **Weight** ______ **BMI** _______

6. FEMALE PATIENTS:

Date of last menstrual period: _______________

Are you now pregnant?	☐ no	☐ yes
Should we test you for pregnancy?	☐ no	☐ yes

\# of previous pregnancies: __________

\# of living children: __________

\# of miscarriages: __________

Identify any pregnancy complications:

7. MALE PATIENTS:

Prostate disorder	☐ no	☐ yes
Erectile problems	☐ no	☐ yes

HAVE YOU EVER HAD OR NOW HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? PLEASE CHECK YES OR NO FOR EACH CONDITION.

(Check "current" if you are currently under any form of treatment for the condidtion)

8. LUNG DISEASE

	Past		Current
Do you use oxygen?	☐ no	☐ yes	☐
Asthma	☐ no	☐ yes	☐
Emphysema	☐ no	☐ yes	☐
Pneumonia	☐ no	☐ yes	☐
Bronchitis	☐ no	☐ yes	☐
Tuberculosis	☐ no	☐ yes	☐
Daily cough	☐ no	☐ yes	☐
Dry cough	☐ no	☐ yes	☐
Productive cough/cough up blood	☐ no	☐ yes	☐
Shortness of breath	☐ no	☐ yes	☐
Wheezing	☐ no	☐ yes	☐
Are you able to walk up 2 flights of stairs without shortness of breath?	☐ no	☐ yes	☐

9. TOBACCO HISTORY

Have you ever smoked regularly?

☐ yes ☐ no ☐ now

☐ pipe ☐ cigar ☐ chew ☐ cigarettes

quantity: ______packs/day and duration: ________years

If you've quit, when did you last smoke? ______________

Date & Location of last chest-x-ray: (if known) ____________

____

10. CARDIOVASCULAR DISEASE

	Past		Current
High blood pressure	☐ no	☐ yes	☐
Abnormal pulse/rhythm/Pacemaker	☐ no	☐ yes	☐
Murmur/Palpitations	☐ no	☐ yes	☐
Ankle swelling/edema	☐ no	☐ yes	☐
Peripheral Vascular Disease/Circulation problems	☐ no	☐ yes	☐
Elevated cholesterol	☐ no	☐ yes	☐
Chest pain/tightness	☐ no	☐ yes	☐
Angina/chest heaviness/heart attack	☐ no	☐ yes	☐
Stent or Cardiac Surgery (date:_________)	☐ no	☐ yes	☐
History Rheumatic Fever	☐ no	☐ yes	☐
Congestive Heart Failure	☐ no	☐ yes	☐
Calf pain when walking	☐ no	☐ yes	☐
How far can you walk until legs are painful __________________	☐ no	☐ yes	☐
Pain in feet at night	☐ no	☐ yes	☐
Does it wake you up	☐ no	☐ yes	☐
Relieved by standing or hanging leg down	☐ no	☐ yes	☐
Leg or Foot ulcers	☐ no	☐ yes	☐
Echocardiogram (date/place:__________)	☐ no	☐ yes	☐
Stress Test (date/place: ____________)	☐ no	☐ yes	☐
Do you have cardiac studies scheduled?	☐ no	☐ yes	☐

11. BLOOD DISORDERS

Anemia/Low blood count	☐ no	☐ yes	☐
Bleeding tendencies/clotting disorder/ Deep Vein Thrombosis	☐ no	☐ yes	☐
Prior transfusion	☐ no	☐ yes	☐
Transfusion reaction	☐ no	☐ yes	☐
Family history of bleeding/clotting disorder/ Deep Vein Thrombosis	☐ no	☐ yes	☐

12. INFECTIOUS DISEASE

Hepatitis A B C	☐ no	☐ yes	☐
MRSA/ Other:________________	☐ no	☐ yes	☐
HIV/AIDS	☐ no	☐ yes	☐

13. TUMORS (specify type and location)

Benign ______________________________

Cancer/malignant ______________________________

14. DIGESTIVE DISORDER

Nausea/vomiting	☐ no	☐ yes	☐
Abdominal pain	☐ no	☐ yes	☐
Ulcer/bleeding	☐ no	☐ yes	☐
Change in stool habits/bloody stools/ black tarry stools	☐ no	☐ yes	☐
Yellow jaundice/Liver Disease	☐ no	☐ yes	☐
Hiatal Hernia/Reflux/Indigestion/Heartburn	☐ no	☐ yes	☐

15. KIDNEY/BLADDER DISEASE

Bladder/Kidney infection	☐ no	☐ yes	☐
Frequent urination/Pain on urination	☐ no	☐ yes	☐
Stones	☐ no	☐ yes	☐
Blood in urine	☐ no	☐ yes	☐
Kidney failure/dialysis	☐ no	☐ yes	☐