Date _____

Meridian Surgical Specialists

Personal Medical Questionnaire

Please answer all the questions to the best of your ability. As major surgery may be considered, please be accurate and complete.

Personal Information

Name _____ Age _____

Primary Care Physician _____

Today's Main Problem

_____

Please list medical conditions currently being treated or of past significance

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Allergies: Please list the drugs you are allergic to, and what happens.

1 _____

2 _____

3 _____

List all current medications and dose

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

List all prior surgeries and approximate dates

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

Any Prior Bleeding or Anesthesia Problem? _____

Family history: Please note if you know of a medical problem in any of your parents, brothers/sisters or children.

Cancer (type?) _____

Heart Disease _____

Anesthesia problems _____

Bleeding disorder _____

Other (list) _____

Review Date

Review Date							

Review of Systems

Patient Name: _____ Date: _____

Please check those items that are true for you <u>in the last three months.</u>

Constitutional

YES/NO

- ❑ ❑ Good health lately?
- ❑ ❑ Are you having a problem with fever or chills?
- ❑ ❑ Have you gained more than 10 lbs. in the last six months?
- ❑ ❑ Have you lost more than 10 lbs. in the last six months?

Heart

YES/NO

- ❑ ❑ Do you have occasional chest pain?
- ❑ ❑ Do your feet swell during the day?
- ❑ ❑ Do you currently have an irregular heartbeat?
- ❑ ❑ Do you currently have a heart murmur?

Lungs

YES/NO

- ❑ ❑ Do you have a cough?
- ❑ ❑ Do you have a problem with shortness of breath?
- ❑ ❑ Have you recently coughed up blood?
- ❑ ❑ Do you have asthma? Have you ever had asthma?
- ❑ ❑ Have you ever had blood clots go to your lungs?

Digestive

YES/NO

- ❑ ❑ Are you experiencing a decrease in your appetite?
- ❑ ❑ Any change in your bowel habits?
- ❑ ❑ Are you having belly pain or cramps?
- ❑ ❑ Have you recently vomited up blood?
- ❑ ❑ Have you recently had blood in your stool?

Urinary

YES/NO

- ❑ ❑ Do you have difficulty with painful urination?
- ❑ ❑ Has your urine been bloody?
- ❑ ❑ Do you wake up more than once to urinate at night?

GYN

YES/NO

- ❑ ❑ Have you ever taken birth control pills?
- ❑ ❑ Are you on hormone replacement?

Number of pregnancies __ Number of births __

When was your Last period? _____

Eyes

YES/NO

- ❑ ❑ Do you usually wear eye glasses or contacts?
- ❑ ❑ Do you have glaucoma?

ENT

YES/NO

- ❑ ❑ Do you have a snoring problem?
- ❑ ❑ Do you have sleep apnea?
- ❑ ❑ Do you wear dentures?
- ❑ ❑ Any recent sinus infections?

Musculo-skeletal

YES/NO

- ❑ ❑ Do you have joint problems like stiff joints?
- ❑ ❑ Do you have a problem with muscle weakness?

Endocrine

YES/NO

- ❑ ❑ Do you get excessively hot or cold as compared to other people?
- ❑ ❑ Have you ever had a goiter or thyroid problem?

Review Date							

Hematologic/Lymphatic

YES/NO

- ❑ ❑ Have you ever had a blood transfusion?
- ❑ ❑ Do you bleed excessively or have a bleeding tendency?
- ❑ ❑ Enlarged lymph nodes?
- ❑ ❑ Blood clots in legs?

Neurological

YES/NO

- ❑ ❑ Headaches
- ❑ ❑ Fainting
- ❑ ❑ Seizures
- ❑ ❑ Paralysis
- ❑ ❑ Stroke or TIA

Skin

YES/NO

- ❑ ❑ Do you have a problem with a rash?
- ❑ ❑ Do you have any skin infections?

Psychiatric

YES/NO

- ❑ ❑ Do you now have memory problems?
- ❑ ❑ Do you have emotional problems?
- ❑ ❑ Do you have a problem with chemical dependency?
- ❑ ❑ Have you been treated for drug or alcohol problems?
- ❑ ❑ Are you taking medication for depression?

Thank you for taking the time to complete this form. We reassure you that the answers will be held in strict confidence. Your efforts will be most helpful in allowing us to provide you the best possible medical care.
Dr. Wright

Clinic Use Only

HPI

CC

Location

Severity

Quality

Timing

Context

Initial

❑ Review of records ❑ Extensive
❑ Reviewed X-Ray, CT, MRI, US
❑ Reviewed studies

Eval	Counseling	Total

❑ 50% time spent in counseling/coordination

Review Date							

Personal Habits

Do you smoke? YES NO How many packs a day? _____

Did you smoke in the past and quit? YES NO Year quit? _____

How many years did you, or have smoked? _____

Do you drink alcohol? YES NO Average drinks per day? _____

Did you drink heavily in the past and quit? YES NO

Do you use street drugs? YES NO Which ones? _____

Are you presently or in the past engaged in any activities that may place you at risk for AIDS, including: IV Street drugs, Blood transfusion Prostitution, Homosexuality, Multiple sexual partners? YES NO

Social History

Employment _____

Highest education _____

Hobbies _____

Religious preference _____

Number of children _____

Current living situation: (Circle answer) Home Nursing Home Family Assisted Living

What is your marital status: (Circle answer) Married Divorced Single Widowed Significant Other

Please Circle the Problems or conditions that you have or may have had in the past

Diabetes	Hospitalization for lung disease
Emphysema	Ulcers
Hypertension	AIDS/HIV
Seizures	Cancer
Problems with anesthesia	Cirrhosis of the liver
Problems with bleeding	Gall bladder disease
Anemia	Steroid use (e.g. Prednisone)
Heart attack	Problem with iodine or seafood

Children Only

Are you up to date on your immunizations? YES NO

Are there special problems you are having at school or home? YES NO

Describe exercise regimen: _____

Review Date							