San Francisco Surgical Medical Group

Please fill out the information below to the best of your ability

Name: _____ Birthdate: _____ Age:____ Today's Date: _____

What name would you prefer to be called? _____

What is the reason for your visit today? _____

MEDICAL HISTORY

Primary Care Physician (include address if not local) _____

Who referred you to our practice? _____ ☐ Same as above

Please list other physicians you wish reports sent to _____

(Mark all that apply)

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding/Blood Disorder
☐ Crohns Disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy/Seizures
☐ Glaucoma
☐ Heart Problems (type _____)
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol or lipids
☐ HIV/AIDS
☐ Irritable Bowel Syndrome (IBS)
☐ Immune Disorder
☐ Kidney Disease
☐ Liver Disease (type _____)
☐ Pneumonia/Bronchitis
☐ Stomach Ulcer/Acid Reflux
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcerative Colitis
☐ Other _____

Please list all of your previous operations and the approximate date (use back side of paper if needed):

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had problems with anesthesia? ☐ No ☐ Yes Explain: _____

Do you have a **pacemaker**, **defibrillator**, or **port**? ☐ No ☐ Yes

If yes, what is the Manufacturer's Name: _____, Model Number: _____

MEDICATIONS

If you don't take any medications, check this box: ☐

Please list the medications (including over the counter) you take regularly and why you're taking it:

1. _____ Reason _____
2. _____ Reason _____
3. _____ Reason _____
4. _____ Reason _____
5. _____ Reason _____
6. _____ Reason _____
7. _____ Reason _____
8. _____ Reason _____
9. _____ Reason _____
10. _____ Reason _____
11. _____ Reason _____
12. _____ Reason _____

If you take a blood thinning medication, which one do you take?
Aspirin, Coumadin, Warfarin, Plavix, Pradaxa, Xarelto, Aggrenox, or other _____

ALLERGIES

If you don't have any known drug allergies, check this box: ☐

Please list the medications that you are allergic to:

1. _____ Reaction _____

2. _____ Reaction _____

3. _____ Reaction _____

4. _____ Reaction _____

Do you have a latex allergy? ☐ No ☐ Yes
Are you allergic to iodine or shellfish? ☐ No ☐ Yes
Do you have an allergic reaction to adhesives/tapes? ☐ No ☐ Yes

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Decline to answer

Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Decline to answer

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily, _____ drinks per day

Use of Tobacco ☐ Never ☐ Previously, but quit: _____ ☐ Current, packs/day: _____

Use of Illicit Drugs ☐ Never ☐ Type/Frequency: _____ ☐ Decline to answer

Do you engage in anal-receptive intercourse? ☐ No ☐ Yes ☐ Decline to answer

FAMILY MEDICAL HISTORY

Has anyone in your family had cancer ☐ No ☐ Yes

Type of cancer _____ Relationship to you _____ Age diagnosed _____

Type of cancer _____ Relationship to you _____ Age diagnosed _____

Type of cancer _____ Relationship to you _____ Age diagnosed _____

Check (✓) if your blood relatives have ☐ Colon polyps ☐ Crohn's or ulcerative colitis ☐ Thyroid/Endocrine Problems

Name: _____ Birthdate: _____ Today's Date: _____

REVIEWS OF SYSTEMS (ROS)

Please only check the boxes only if they are bothering you TODAY

CONSTITUTIONAL SYMPTOMS
- ☐ Good General Health
- ☐ Recent Weight Change
- ☐ Fever/Sweats
- ☐ Fatigue
- ☐ Headache

SKIN
- ☐ Rashes
- ☐ Psoriasis
- ☐ Bruise Easily
- ☐ Abnormal Lumps
- ☐ *No symptoms*

NOSE
- ☐ Sinus Problems
- ☐ Breathing Problems
- ☐ *No symptoms*

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ *No symptoms*

EARS
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ *No symptoms*

GENITOURINARY
- ☐ Blood in Urine
- ☐ Frequency of Urination
- ☐ Painful Urination
- ☐ Loss of Bladder Control
- ☐ Enlarged Prostate
- ☐ *No symptoms*

GASTROINTESTINAL
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Loss of Bowel Control
- ☐ *No symptoms*

ENDOCRINE
- ☐ Excessive Thirst/Appetite
- ☐ *No symptoms*

NEUROLOGIC
- ☐ Headache/Migraine
- ☐ Dizziness
- ☐ *No symptoms*

EYES
- ☐ Visual Loss
- ☐ Double Vision
- ☐ Painful Eyes
- ☐ *No symptoms*

THROAT
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Snoring
- ☐ *No symptoms*

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ *No symptoms*

MUSCULOSKELETAL
- ☐ Fractures/Sprains
- ☐ Osteoporosis
- ☐ Joint Swelling
- ☐ *No symptoms*

OTHER
- ☐ Pregnant: _____ weeks

_____
_____
_____
_____
_____

Reviewed by: _____ Date: _____

MEDICAL ASSISTANTS USE ONLY

Ht: _____ Wt: _____ BP: _____ P: _____ T: _____

Smoker: non / current / quit Allergy: NKDA /_____ Pacemaker: Yes / No