THE SURGICAL CLINIC

Patient Account #

Medical Questionnaire

Date of appointment: _____

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Referring Provider: _____ **Primary Care Provider:** _____

What problem are you being seen for today?
Describe your symptoms?
When did your symptoms begin?
How long do they last?
What makes them worse?
Does anything make them better?
Pain on a scale of 1 (= no pain) to 10 (= unbearable)? #:
Have you been treated for this before? When? By whom?

MEDICAL HISTORY: Are you under treatment for or have you been treated for any of the following? :		
☐ Anesthesia Problems	☐ Respiratory Problems	☐ Lung problems
☐ Diabetes	☐ Kidney problems	☐ Vascular problems
☐ Liver problems	☐ Heart problems	☐ High cholesterol
☐ Stroke	☐ Cancer/Kind	☐ High blood pressure
☐ Hepatitis	☐ Bleeding Problems	☐ Other

Have you ever had surgery? **If yes, please list below:**			
Date of Surgery	**Type of Surgery**	**Location/ hospital**	**Complications**

What medications are you sensitive to or allergic to?	**How does your body react to taking it?**
1)	Reaction:
2)	Reaction:

What medications and/or supplements do you take?	**Why do you take them?**	**What strength & how often?**
Pharmacy: **Phone:**	**Address:**	

MEDICAL ASSISTANT WILL FILL OUT THIS INFORMATION:

Pulse: _____ O2 Sat Rate: _____ Blood Pressure: R: _____/_____ L: _____/_____

Height: _____ Weight: _____

DIALYSIS PATIENTS ONLY: Please provide treatment information below.
Dialysis Days (Circle days): Monday Tuesday Wednesday Thursday Friday Saturday Sunday
Dialysis Times:
Facility Name:
Location:

Do you have a family history of? (Circle all that apply)

Stroke	Diabetes	Heart Disease	High Blood Pressure	Cancer
Father	Father	Father	Father	Father
Mother	Mother	Mother	Mother	Mother
Sister	Sister	Sister	Sister	Sister
Brother	Brother	Brother	Brother	Brother
Grandfather	Grandfather	Grandfather	Grandfather	Grandfather
Grandmother	Grandmother	Grandmother	Grandmother	Grandmother
Aunt	Aunt	Aunt	Aunt	Aunt
Uncle	Uncle	Uncle	Uncle	Uncle
Cancer – If so what type of cancer?				
Tobacco use (includes snuff, cigars, chewing tobacco, cigarettes, etc.)				
☐ Yes		☐ Not now		☐ Never
Indicate usage: (packs/day, cigarettes/day, cans of snuff/day, etc.)				

Marital Status	☐ Married	☐ Single	☐ Separated	☐ Divorced	☐ Widowed
Who lives with you?					
Your occupation?					

Alcohol use:	☐ Yes	☐ Not now	☐ Never
How much, how often?			
Drug use:	☐ Yes	☐ Not now	☐ Never
Type and frequency?			

WOMEN ONLY:		Date of Last Menstrual Period _____	Date of last pap smear? _____	
PREmenopausal Yes ☐ NO	POSTmenopausal Yes ☐ NO	Are you pregnant? Yes ☐ NO	Could you be pregnant? ☐ Yes No ☐	Date of last mammogram/results

Please check any box below that applies to you now or in the past 6 months:

☐ Good General Health	☐ Nausea/Vomiting	☐ Coughing up blood	☐ Blood in urine
☐ Recent Weight Change	☐ Abdominal pain	☐ Wear glasses/contacts	☐ Kidney stone
☐ Night sweats	☐ Rectal bleeding	☐ Blurred/double vision	☐ Sexual problems
☐ Fever	☐ Bowel problems	☐ Eye Disease or Injury	
☐ Fatigue	☐ Hearing loss	☐ Glaucoma	**MEN:**
☐ History of MRSA	☐ Ears ringing	☐ Change in hair or nails	Date of last prostate exam?
☐ Chest Pain	☐ Sinus problems	☐ Rash/itching	
☐ Palpitations	☐ Nose bleeds	☐ Insomnia	**EVERYONE:**
☐ Heart Problems	☐ Sore throat	☐ Confusion	Date of last stool study?
☐ Swelling hands/feet	☐ Voice change	☐ Memory loss	
☐ Excessive Thirst	☐ Muscle Pain/Cramps	☐ Depression	Date of last colonoscopy?
☐ Frequent Urination	☐ Stiffness/Swelling Joints	☐ Frequent Headaches	
☐ Thyroid Disease	☐ Joint pain	☐ Paralysis or Tremor	Date of flu shot?
☐ Hormonal problems	☐ Trouble walking	☐ Convulsions or Seizures	
☐ Easily Bruised	☐ Shortness of breath	☐ Tingling or Numbness	
☐ Slow to heal	☐ Cough	☐ Breast lump	
☐ Enlarged Glands	☐ Wheezing/Asthma	☐ Breast pain or discharge	

To the best of my knowledge, the above information is accurate and complete:

_____ _____

Patient's (or authorized person's) signature *Date*

_____ Information Updated & Reviewed by: _____

Physician *TSC Staff*