Advanced Surgical Associates Patient Worksheet

Name:_____ **Age:**_____ **Acct#:**_____

Reason For Visit:_____

Medical History: check all that apply

High BP	Diabetes	Heart	Stroke	Thyroid Disease
Cancer	Asthma	Arthritis	Ulcers	Liver Disease
Bladder	Kidney	Pneumonia	Prostate	Gastrointestinal

Other_____

Other_____

Surgical History: check all that apply and write year of surgery

Gallbladder/Date:_____	Hernia/Date:_____	Breast/Date:_____
Colon/Date:_____	Hysterectomy/Date:_____	Kidney/Date:_____
Heart Bypass/Date:_____	Thyroid/Date:_____	Reflux/Date:_____

Other/Date:_____

Other/Date:_____

Medication/Dose:

1)_____	5)_____
2)_____	6)_____
3)_____	7)_____
4)_____	7)_____

Medication Allergies:

No Drug Allergies

or

1)_____	5)_____
2)_____	6)_____
3)_____	7)_____
4)_____	8)_____

Social History:

Tobacco	Packs/day_____	# of Years_____
	Quit Y / N	Year_____
Alcohol	# of Drinks_____	per Day / Week / Month

Other Drug Use:_____

Occupation:_____

Family Medical History:

Mother:_____

Father:_____

Sisters:_____

Brothers:_____

Children:_____

Grandparents:_____

Review of Symptoms: circle any that apply

Head/Neck	Blurred Vision	Ear Aches	Nosebleeds	Enlarged Lymph Node
Throat	Sore Throat	Ulcers	Loose teeth	
Chest	Cough	Sputum	Wheezing	Short of Breath
Heart	Chest Pain	Irregular heartbeat		
Back	Sore Back	Shoulder Pain		
Abdomen	Bloating	Nausea	Diarrhea	Constipation
Rectal	Bloody Stools	Pain with BM		
Extremities	Leg Pain with Walking		Ulcers	Varicose veins
Neuro:	Headache	Seizures	Weakness	Paralysis
Skin:	Rashes	Abscess	Cysts	Enlarging moles
Urinary:	Bloody Urine	Painful Urination		
Other:	Fever	Chills	Vomiting	Night Sweats

This health information sheet is accurate to the best of my knowledge.

Patient Signature:_____

Date:_____

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