Surgical Specialists of Clear Lake

Medical History

Patient Name: ____________________________ **DOB:**_______________ **Sex:** _____ **Date:** ____________________

Height: ______ **Weight:** _______ **Pharmacy Name/Phone Number:** ______________________________________

PREVIOUS ILLNESSES (Please list any illness you have had, and the dates of their occurrence)

____ ____
____ ____
____ ____

PREVIOUS COLON SCREENING (Please list the most recent colon screenings you have undergone and the dates of their occurrence)

☐ Flexible Sigmoidoscopy _____________________ ☐ Colonoscopy____

☐ Barium Enema ___________________________

PAST SURGICAL HISTORY (Please list all operations you have had and the dates of occurrence)

____ ____
____ ____
____ ____

MEDICATION (Please list all medications that you are currently taking and their doses. Please include over the counter and Herbal medications)

_____________________________________ Please note if you are on the following specifically.

_____________________________________ Plavix ☐ Coumadin/Warfarin ☐ Aspirin ☐ Ticlid ☐

_____________________________________ ____

ALLERGIES (Please list any medication you are allergic to and explain the reaction to the medication)

☐ No Known Drug Allergies________________ ____

_____________________________________ ____

FAMILY HISTORY (Please list your family member and the disease associated)

☐ Colon Cancer___________________________ ☐ Other____

☐ Rectal Cancer_________________________ ____

☐ Polyps_____________________________ ____

REVIEW OF SYSTEMS (Do you currently have or had a history of the following? Please check all that apply. If you do not check the box, we assume that the answer is no)

General
- ☐ Recurrent Fever
- ☐ Significant weight Change

Eye, Ear & Throat
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinopathy
- ☐ Sinus problems
- ☐ Dental problems
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Recent sore throat
- ☐ Difficulty swallowing

Hematologic
- ☐ Anemia
- ☐ Blood disorder

Oncologic
- ☐ Chemotherapy
- ☐ Radiation

Cardiovascular
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Abnormal heart valve
- ☐ Swollen feet
- ☐ Abnormal stress test
- ☐ Pacemaker
- ☐ Blood thinner use
- ☐ High Cholesterol

Abdominal/GI
- ☐ Hernia
- ☐ Nausea/vomiting
- ☐ Reflux
- ☐ Peptic Ulcer
- ☐ Jaundice

Dermatologic
- ☐ Rash
- ☐ Skin Cancer

Urologic
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urinary Incontinence

Male Reproductive
- ☐ Prostate gland problems
- ☐ Abnormal PSA
- ☐ Difficulty urinating
- ☐ Penile discharge
- ☐ Testicular pain/mass

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Hormonal abnormalities
- ☐ Steroid use

Rheumatologic
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Arthritis

Female Reproductive
- ☐ Irregular Menstruation
- ☐ Vaginal spotting
- ☐ Vaginal Cysts
- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Number of previous pregnancies___

Respiratory
- ☐ Sleep apnea
- ☐ Productive cough
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Wheezing

Neurologic / Psychiatric
- ☐ Stroke
- ☐ Seizure
- ☐ Depression
- ☐ Phobia
- ☐ Fainting or blackouts
- ☐ Anxiety

Personal Habits
- ☐ Do you smoke? Y N
- ☐ Do you drink al alcohol? Y N

Other

____
____
____

Referring Physician: ____

Patient Signature: ____ **Date:** ______________________________________