Westside Surgical Associates, LLP

Date:_____

Name: _____ Ht: _____

Date of Birth:_____ Wt: _____

Sex: M____ F___ BMI: _____

Allergies to Medications/Latex – please include type of reaction

1.
2.
3.
4.
5.

Current Medications – include Herbal and over the counter medications; dosage and frequency

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Surgical History/Hospitalization – include any illness, surgery, injury and dates

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

PATIENT NAME: _____ DATE OF BIRTH: _____

Medical History

Have you had any of the following?		Please specify and give details
Diabetes	Yes No	
Heart Disease	Yes No	
Kidney Disease	Yes No	
Sickle Cell Anemia	Yes No	
Spleen removed	Yes No	
Alcoholism or heavy alcohol use	Yes No	
Hepatitis or Cirrhosis	Yes No	
Cancer	Yes No	
Mitral Valve Prolapse	Yes No	
Rheumatic Fever	Yes No	
Artificial heart valve	Yes No	
Endocarditis (heart valve infection)	Yes No	
Tuberculosis (or positive skin test)	Yes No	
High cholesterol (level and date)	Yes No	
High blood pressure	Yes No	
Heart attack	Yes No	
Coronary bypass surgery	Yes No	
Angina/chest pain	Yes No	
Stroke or TIA (mini stroke)	Yes No	
Atrial fibrillation (irregular beat)	Yes No	
Ovaries removed before menopause	Yes No	
Venereal disease	Yes No	
AIDS or AIDS virus (HIV)	Yes No	
Thyroid/goiter	Yes No	
Seizure disorder	Yes No	
Rheumatoid arthritis	Yes No	
Stomach ulcer	Yes No	
Blood Disease/Bleeding Disorder	Yes No	
Bloody bowel movements	Yes No	
Dark, tarry bowel movements	Yes No	
Last colonoscopy	Yes No	Date:
Other problems:	Yes No	

Past Family History

	List health problems; if deceased, provide age and cause.
Father	
Mother	
Brother(s)	
Sister(s)	
Other	

(Heart disease, high blood pressure, diabetes, emphysema, kidney disease, stroke, high cholesterol, glaucoma, Alzheimer's, tuberculosis, bleeding tendency, cancer (type), osteoporosis, birth defects, miscarriage)

PATIENT NAME: _____ DATE OF BIRTH: _____

Smoking: Do you smoke? Yes___ No___ Have you ever smoked? Yes___ No___
Number of years___ Cigarettes___ Cigars___ Pipe___ Packs per day___

Nutrition: Have you lost or gained 10 or more pounds in the last month? Yes__ No__
Significant problems swallowing or chewing? Yes___ No___
Decrease in appetite? Yes___ No___

Exercise: Do you exercise regularly? Yes___ No___
How often and what type of exercise? _____

Alcohol: How many drinks do you have a day/week? (include what type)

_____

Drugs: Do you now or have you ever used drugs? Yes___ No___
Have you ever used I.V. drugs (with needles)? Yes___ No___
If so, when was the last time? _____

Sexual History: Do you have any risk factors for AIDS? (multiple partners, sex with a prostitute, homosexual intercourse, history of sexually transmitted disease) Yes__ No__

Women only: How many times have you been pregnant? _____ Live births_____
Miscarriages_____ Abortions_____
When was your last menstrual period?_____ Are your cycles regular? Yes___ No___
Date of your last pap smear_____ Year of your last mammogram_____
Do you do self breast exam? Yes___ No___ How often?_____

Men only: What year was your last rectal/prostate exam?_____
Do you have difficulty starting your stream or with dribbling? Yes___ No___
Any blood in your urine? Yes_____ No____

Social History:

Who lives at home with you (name, relationship and age)?

PATIENT NAME: _____ DATE OF BIRTH: _____

Educational Background: Grade school___ HS___ College___ other___
Preferred method of learning: reading___ discussion___ demonstration___
hearing___ doing___
Primary Language: _____
List any other information about yourself that would be helpful when we provide you with health teaching:_____

Environmental Exposure: Has your job or hobby exposed you to toxic substances (pesticides, solvents or asbestos) Yes___ No___

Pain Screen: Have you had pain in the last week? Yes___ No___
On a scale of 0-10 (0=no pain, 10 being the worst pain), how would you rate your worst pain this week? 0 1 2 3 4 5 6 7 8 9 10

If you rated your pain 4 or greater, please answer the following questions:
Where is your pain located?_____
Describe the pain (stabbing, cramping, sharp, dull, spasms)_____
How long have you had the pain?_____
What relieves the pain?_____
Does your pain limit your activities?_____
What increases the pain?_____
Are you using other treatments for your pain?_____

-OPTIONAL-
Within the last year, have you been verbally, emotionally, sexually or physically harmed or threatened by your partner or any one else? Yes___ No___
Within the last year, have you felt afraid or unsafe with your partner or any one else? Yes___ No___

Do you wear a seatbelt when you drive? Always___ Usually___ Seldom___ Never___
Do you wear a bike helmet when cycling? Always___ Usually___ Seldom___ Never___
Do you have a smoke detector in your house? Yes___ No___
Do you have a carbon monoxide detector in your house? Yes___ No___
Do you own a gun? Yes___ No___

History reviewed directly with patient.

_____ _____ _____ _____
Jennifer Griffith, MD Pasquale Iannoli, MD Brent Miller, DO Thomas Russo, DO