# NORTH ATLANTA SURGICAL ASSOCIATES

**Date**_____ **Name**_____ Age_____ Height_____ Weight _____

Reason for coming to the doctor _____

Person(s) to notify in case of emergency
Name_____ Relationship_____ Home #_____ Work # _____
Name_____ Relationship_____ Home #_____ Work # _____
Name_____ Relationship_____ Home #_____ Work # _____

Allergies and reactions: ❑ None or list: _____

**List all medications you take:**

| Medication | Dose/how often | Last dose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Medication | Dose/how often | Last dose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**List all previous operations/therapy/procedures/radiation or chemotherapy/central line placement**

| Operation/therapy/procedure | Anesthesia | Complications | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Any religious beliefs affection health care (eg: blood transfusions) ❑ No ❑ Yes: Explain_____

Have you or a family member had any serious problems with operations or anesthetics? ❑ No ❑ Yes: Explain_____

_____

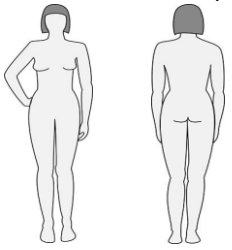
Family medical history: ❑ Heart disease ❑ Cancer ❑ Diabetes ❑ Other _____ ❑ None

Primary/regular physician:_____ Phone_____ Date last seen _____

Specialist (eg: cardiologist) _____

**Check if you have ever had any of the following:**

**Habits ❑ None**
❑ tobacco: type_____ amount/packs per day_____ # of years_____ if stopped when_____
❑ alcohol use: amount_____ how often_____ time last use_____
❑ recreational or illegal drug use: type_____ amount_____ time last use_____
❑ caffeine use: daily amount_____
❑ exercise: type_____ how often_____

| Oral | General | Vision & Hearing | Musculoskeletal | Skin | Notes |
|---|---|---|---|---|---|
| ❑ dentures (upper/lower)<br>❑ teeth missing, loose, chipped<br>❑ TMJ problems<br>❑ caps, crown, bonding<br>❑ bridge (permanent, removable)<br>❑ **None** | ❑ HIV / AIDS<br>❑ cancer (site: _____)<br>❑ transfusion reaction<br>❑ sickle cell disease<br>❑ **None** | ❑ contacts, glasses<br>❑ artificial/glass eye<br>❑ glaucoma<br>❑ cataracts<br>❑ hearing aid<br>❑ hard of hearing, deaf<br>❑ **None** | ❑ back/neck pain<br>❑ cane, walker, crutches<br>❑ leg cramping<br>❑ artificial arm/leg<br>❑ muscles weak<br>❑ arthritis<br>❑ **None** | ❑ current bruises, rash<br>❑ current burns<br>❑ current wounds, sores, ulcers<br>❑ problems with tape, type: _____<br>❑ **None** | STAFF USE ONLY<br>❑Pediatric/Adolescent Questionnaire <=17yr<br>  |

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| | | |
|---|---|---|
| **Cardiovascular**<br>❑ heart attack<br>❑ chest pain, angina<br>❑ irregular pulse<br>❑ cardiac arrest<br>❑ high blood pressure | ❑ congestive heart failure<br>❑ pacemaker<br>❑ murmur<br>❑ rheumatic fever<br>❑ mitral valve prolapse<br>❑ anemia | ❑ circulation problems<br>❑ blood clots, phlebitis<br>❑ free bleeder<br>❑ hemophilia<br>❑ bruise easily<br>❑ **none** |
| **Respiratory**<br>❑ bronchitis<br>❑ chronic cough<br>❑ asthma, wheezing<br>❑ emphysema, COPD | ❑ pneumonia<br>❑ shortness of breath<br>❑ home oxygen therapy<br>❑ tracheostomy<br>❑ tuberculosis (TB) | ❑ sinus problems<br>❑ sleep apnea<br>❑ collapsed lung<br>❑ **none** |
| **Neurological**<br>❑ seizures<br>❑ paralysis<br>❑ head injury | ❑ stroke<br>❑ spinal cord injury<br>❑ numbness or tingling | ❑ migraine headaches<br>❑ fainting<br>❑ **none** |
| **Gastointestinal**<br>❑ hiatal hernia, reflux, heartburn<br>❑ peptic ulcer<br>❑ bowel disease<br>❑ abdominal pain<br>❑ hepatitis: type_____ year_____ | ❑ low blood sugar<br>❑ gall bladder problems<br>❑ liver disease<br>❑ diet, food intolerance<br>❑ hemorrhoids<br>❑ constipation | ❑ swallowing problems<br>❑ recent vomiting or diarrhea<br>❑ loss of appetite<br>❑ recent weight gain/loss<br>❑ ostomy: type_____<br>❑ **none** |
| ❑ **Diabetes** **controlled by:** | ❑diet ❑ insulin ❑ oral medication | ❑ **none** |
| ❑ **Thyroid Disease** | ❑overactive ❑ underactive | ❑ **none** |
| **Genitourinary**<br>❑ kidney stones<br>❑ difficulty with control<br>❑ catheter, self catheter<br>❑ blood in urine | ❑ frequent urine infections<br>❑ difficulty with urination<br>❑ painful or frequent urination<br>❑ kidney disease<br>❑ dialysis: type_____ | ❑ prostate disease<br>❑ last prostate check:_____<br>❑ sexual problems<br>❑ **none** |
| **Gynecological**<br>Are you pregnant?<br>❑ No ❑ Yes, # weeks: _____ | Is there any chance you are pregnant?<br>❑ No ❑ Yes<br>Date of 1st day of last period_____ | Date of last mammogram_____<br>Date of last pap smear_____<br>❑ heavy, painful or irregular periods<br>❑ none |
| **Emotional Health**<br>Do you have any emotional needs, recent personal changes, or past history that you would like to make us aware of?<br>❑ depression<br>❑ catastrophic news | ❑ marriage<br>❑ domestic violence<br>❑ loss of baby<br>❑ job loss or new job<br>❑ psychological/substance abuse therapy as ❑ inpatient ❑ outpatient | ❑ abuse (emotional, physical, sexual)<br>❑ divorce<br>❑ death of someone close to you<br>❑ **none** |
| **Spiritual/Cultural Needs**<br>Do you have any spiritual, emotional or cultural needs that you would like to make us aware of? | ❑ clergy to be called<br>❑ health care treatment concerns affected by religious/cultural beliefs<br>❑ religious practice/special days | ❑ dietary<br>❑ sacramental needs<br>❑ **none** |
| **Any significant health problems not listed above?** ❑ No ❑ Yes, explain:_____ | | |