What is your reason for seeing the surgeon? ________________

Have you travelled outside the state in the past 30 days? [ ] Yes [ ] No

Have you had a pneumococcal vaccine? [ ] Yes [ ] No

Are you in pain? [ ] Yes [ ] No If yes, where? ________________

Quality of pain: [ ] Cramping [ ] Squeezing [ ] Burning [ ] Stinging [ ] Stabbing [ ] Other: ________________

On a scale of 1 (weak) to 10 (extreme), how severe is your pain? ______ How long does it usually last? ______

Have you fallen in the past 12 months? [ ] Yes [ ] No

Are you a smoker? [ ] Yes [ ] No [ ] Former

If Yes, how many years have you smoked? ________________

If Former, how many years did you smoke? ________________

----------

Review of Systems

Please check boxes to indicate if you have any of the following problems:

CARIOVASCULAR

☐ Chest Pain
☐ High Blood Pressure (Hypertension)
☐ Heart Attack
  If yes, when? ________________

☐ Heart Failure
☐ Palpitations/Irregular Heart Beat
☐ Valve Disease / Rheumatic Fever

NEUROLOGICAL

☐ Anxiety
☐ Depression
☐ Stroke/TIA
  If yes, when? ________________

☐ Seizure
☐ Other Mental Illness:

☐ Renal Failure
☐ Chronic Kidney Disease
☐ Nephrotic Syndrome

☐ Renal/Prerenal Insufficiency
☐ Problems with Urinating

☐ Severe Acidosis
☐ Ketoacidosis

☐ Other Renal problems:

☐ Renal/Liver transplantation

☐ Renal transplantation

☐ Other:

HEMATOLOGY

☐ Anemia

☐ History of Blood Transfusions?
  [ ] Yes [ ] No

☐ Blood Clots, DVT or Pulmonary Embolism?
  If yes, when? ________________

☐ Other:

MUSKULOSKELTAL

☐ Arthritis
☐ Back Pain
☐ Difficulty Walking
☐ Joint Pain

☐ Other:

REPRODUCTIVE

☐ Infertility

☐ Other:

ENDOCRINE

☐ Diabetes
☐ Hypothyroidism
☐ Hypopituitarism

☐ Other:

GASTROINTESTINAL

☐ Constipation
☐ Diarrhea
☐ Difficulty Swallowing
☐ Heartburn

☐ History of Stomach Ulcers
☐ Nausea
☐ Regurgitation of Food
☐ Vomiting

☐ Other:

GENERAL

☐ Cancer
  If Yes, what type? ________________

☐ Fever
☐ Recent Weight Loss

☐ Other:

----------

Supplemental Family Medical History

Please select any known family history of health problems:

<table>
<thead>
<tr>
<th></th>
<th>Diabetes</th>
<th>Heart Disease</th>
<th>Breast Cancer</th>
<th>Colon Cancer</th>
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<tbody>
<tr>
<td>Father</td>
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<tr>
<td>Mother</td>
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<td>Brother</td>
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<td>Maternal Grandfather</td>
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<td>Daughter</td>
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<td>Son</td>
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Other Cancer:

Patient Signature: X __________________________ Date: _____/_____/______
SUPPLEMENTAL MEDICAL QUESTIONNAIRE

Surgeries: (Please note any past surgeries, or select “NONE”)

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<td>Year:</td>
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Medications: (Please list medications and dosage, or select “NONE”)  Dosage:

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Are you allergic to: [ ] Tape  [ ] Latex  [ ] Iodine

Medication Allergies: (Please list medications and dosage, or select “NONE”)

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Social History:

Marital Status: [ ] Single  [ ] Married  [ ] Separated  [ ] Divorced  [ ] Widowed

Number of children: ________________________________

Occupational Status: [ ] Disabled  [ ] Retired  [ ] Unemployed  [ ] Employed

Occupation: ______________________________________

Alcohol Intake: [ ] Never  [ ] 1 Drink Daily  [ ] 2+ Drinks Daily  [ ] Few Drinks a Week

[ ] Few Drink a Month  [ ] Occasional (Holidays / Special Occasions)

*Preferred Pharmacy:

Name: ________________________________________________

Location: ________________________________________________

Is there anything else that you would like your surgeon to know?

________________________________________________________________________

________________________________________________________________________

Patient Signature: X______________________________ Date: __/__/_______