

**Central Carolina Surgery, P.A. - Patient Medical History - CCS Surgeon \_\_\_\_\_**

Patient Acct. # \_\_\_\_\_ Patient Name \_\_\_\_\_

Email Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Reason for visit/chief complaint \_\_\_\_\_

Primary Care MD \_\_\_\_\_ MD requesting consult \_\_\_\_\_

**Medical Conditions or hospitalizations (please list):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries (please list procedure(s) and date(s)):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications You Currently Take (prescription, "over the counter medicine", herbal supplements)**

<u>Name of Medicine</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy of choice \_\_\_\_\_ Phone \_\_\_\_\_

Any allergies to medications?  Yes  No If Yes, please list \_\_\_\_\_

Do you take? Aspirin  Yes  No Plavix  Yes  No Coumadin/Warfarin  Yes  No

Are you allergic to Latex?  Yes  No Are you diabetic?  Yes  No

**(PLEASE TURN OVER AND COMPLETE THE BACKSIDE OF THIS SHEET)**

I hereby acknowledge that the completed information is correct to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**Family History** (list any illnesses of family members, i.e. cancer, heart, diabetes, etc.)

Father:  Living  Deceased Illnesses \_\_\_\_\_

Mother:  Living  Deceased Illnesses \_\_\_\_\_

Brother(s): How many Living \_\_\_\_\_ How many Deceased \_\_\_\_\_ Illnesses \_\_\_\_\_

Sister(s): How many Living \_\_\_\_\_ How many Deceased \_\_\_\_\_ Illnesses \_\_\_\_\_

**Social History - Occupation:** \_\_\_\_\_

Marital Status  Single  Married  Widowed  Divorced  Other: \_\_\_\_\_

Number of Children \_\_\_\_\_ Do you smoke?  Yes  No If yes, how many packs per day \_\_\_\_\_

Do you drink?  Yes  No If yes, how much \_\_\_\_\_

**Please check box if you have had any problems in any of the designated areas. If normal, check the normal box.**

**General**

- Normal
- Fever
- Weight change
- Night sweats
- Chills
- Loss of sleep/fatigue

**Breast**

- Normal
- Lump
- Pain
- Nipple discharge
- Infection

**Infections Diseases**

- Normal
- HIV/AIDS
- Tuberculosis
- Hepatitis A
- Hepatitis B
- Hepatitis C
- STD
- MRSA

**Dental**

- Normal
- Dentures/Gum disease
- Other

**Cardiac**

- Normal
- Pacemaker
- Defibrillator
- Bypass surgery
- High blood pressure
- Heart disease
- Poor circulation
- Heart attack

**Pulmonary**

- Normal
- Cough/Sputum
- Bronchitis
- Asthma
- Shortness of breath
- Pneumonia

**Endocrine**

- Normal
- Diabetes
- Thyroid disease
- High cholesterol

**Skin**

- Normal
- Rash/Bruise easily
- Cancer
- Abnormal moles

**Gastrointestinal**

- Normal
- Nausea/vomiting/diarrhea
- Colon polyp or cancer
- Irritable bowel disease
- Poor appetite
- Hiatal hernia or reflux
- Ulcer
- Liver disease
- Abdominal pain
- Hernia
- Rectal bleeding or hemorrhoids

**GU**

- Normal
- Kidney disease or kidney stone
- Prostate
- Blood in urine
- Difficulty urinating
- Incontinence

**Neurological**

- Normal
- Stroke/Paralysis/Seizure
- Dizziness/Weakness/Fainting
- Headaches
- Alzheimer's

**Hematological/Lymphatic**

- Normal
- Bleeding disorder
- Blood clots
- Swollen lymph nodes
- Anemia
- Blood transfusions

**Immune System**

- Normal
- Previous/Current cancer
- Type: \_\_\_\_\_

**HEENT**

- Normal
- Hearing loss/hearing aid
- Ear infection
- Sinus problems/Runny nose
- Nose bleed
- Hoarseness/Sore throat
- Blurred or double vision
- Glasses or contacts
- Glaucoma or retinopathy

**Musculoskeletal**

- Normal
- Joint pain/arthritis
- Other

**OB-GYN**  Normal

Currently pregnant  Trying to conceive 1st period \_\_\_\_\_ 1st pregnancy \_\_\_\_\_

Breast Fed:  Yes  No Menopause:  Yes  No Hormone therapy:  Yes  No

Family History of Breast Cancer:  Yes  No