Innovative Surgical Care, PC

Date:_____

HISTORY FORM

Patient Name:_____ DOB:_____
Primary Care Physician:_____Referring Physician:_____
Reason for Todays Visit :_____
Phone :_____ Pharmacy: Number/address:_____

**Is todays visit a result of a MOTOR VEHICLE ACCIDENT?_____ WORKERS COMP?_____
(*PLEASE NOTIFY FRONT DESK IF YOU ANSWERED "YES" TO ANY OF THE ABOVE)*

Current Medications *and* reason for taking specified Medication :

_____
_____
_____

Allergies to Medications: _____Latex allergy?_____

Prior Surgeries and Approximate dates: _____
_____

Have **YOU** had any of the following?

Heart Disease	YES	NO	If YES, Please Describe: _____
Lung Disease	YES	NO	_____
Kidney Disease	YES	NO	_____
Vascular Disease	YES	NO	_____
Diabetes	YES	NO	_____
Easy Bruising	YES	NO	_____
High Blood Pres.	YES	NO	_____
Cholesterol	YES	NO	_____
Stroke	YES	NO	_____
Cancer	YES	NO	_____

OTHER _____
_____

Is there any **FAMILY** history of : (Please Specify Relative Affected)

Heart Disease	YES	NO	_____
Lung Disease	YES	NO	_____
Kidney Disease	YES	NO	_____
Vascular Disease	YES	NO	_____
High Blood Pres.	YES	NO	_____
Diabetes	YES	NO	_____
Cancer	YES	NO	_____

Have you had the following vaccinations:

FLU SHOT _____Date:_____PNEUMOVAX_____Date:_____

*Do you have a Legal Health Care Proxy? _____

*Do you Smoke? YES NO Packs/Day?_____How many years?_____

*Do you Drink Alcohol? YES NO DAILY: _____WEEKLY?_____MONTHLY_____

*Do you use illegal Substances? YES NO Specify:_____

REVIEW OF SYSTEMS: ***Please specify any problems you may be experiencing:***

1. Constitutional (Weight loss/gain, fever, chills, malaise, night sweats Etc.). YES NO
   _____
2. Eye Problems (Blindness, Glaucoma, Vision Problems Etc.) YES NO
   _____
3. Ear, Nose, and Throat Issues (Hearing Loss, Other Problems) YES NO
   _____
4. Respiratory Issues (Cough, Wheezing, Chest Pain Etc.) YES NO
   _____
5. Gastrointestinal (GERD, Diarrhea, Constipation, Abdominal Pain Etc) YES NO
   _____
6. Musculoskeletal Problems (Muscles, Joints, Bones) YES NO
   _____
7. Integumentary Complaints (Skin, Hair, Nails Etc) YES NO
   _____
8. Breast Complaints YES NO
   _____
9. Neurological (Headache, dizziness, vertigo, syncope Etc) YES NO
   _____
10. Psychiatric Problems YES NO
    _____
11. Endocrine Problems (Thyroid, Parathyroid, pancreas Etc.) YES NO
    _____
12. Immunological (Infections, AIDS, Etc.) Hematological/Lymphatic (Blood, bleeding, Lymphoma) YES NO
    _____

******Have you had any previous Imaging studies done Related to the Problem you are being seen for today? *PLEASE CIRCLE*******

X-RAY CT SCAN MRI ULTRASOUND MAMMOGRAM OTHER: _____

Is there anything else you would like to tell us, INCLUDING Special Requests you may have? :

_____

_____