Surgical Clinic Associates, P.A.

History Form

Date: _____ MRN#_____

Patient Name: _____ Age: _____

Why are you seeing the doctor today? _____

When did your problem start? _____ Referring Doctor: _____

Pharmacy (Name, Address and Phone number) _____

Medical History: (Please Circle)

- Abnormal weight loss Abnormal weight gain Alcoholism Alzheimer's Disease
- Angina Anxiety Disorder Arthritis Asthma Auto Immune Disease Bronchitis Cancer _____
- Congestive Heart Failure Crohn's Disease Diabetes: (Type 1) (Type II) (unknown) Diverticulitis
- Esophageal Reflux Free Bleeder Heart Palpitations Heart Attack Hepatitis (A, B, or C)- Circle one
- HIV/AIDS Hypertension Obesity Peptic Ulcer Disease Pneumonia Seizures Sickle Cell
- Sleep Apnea Stroke Ulcerative Colitis Vascular Disease **No Past Medical History**
- Other_____

Surgical History: (Please Circle)

- Adenoids/ Tonsils/ Both Appendix Back Surgery Brain Breast Colon
- C-Section GallBladder Heart Hemorrhoids Hernia _____ Hysterectomy Lung Reflux
- Thyroid Vascular Surgery **No Previous Surgery**
- Other_____

Family History: (Please Circle)

- Breast Cancer Ovarian Cancer Colon Cancer Heart Attack Sickle Cell **No Family History**
- Other_____

Allergies: **Do you have Allergies? Yes Or No** (If **YES**, please list) _____

_____

Social History: **Smoke:** Yes Not Anymore Never **Drink Alcohol:** Yes Not Anymore Never

Reproductive History: Number of Pregnancies: _____ Number of Children: _____

Did you breast feed? YES NO