Lakeview General Surgery

Name_____ **Marital Status:** Single, Married, Other (circle)

Who is your referring provider? _____

What problem brings you into the office today? _____

_____

Please list all other medical problems: _____

_____

_____

_____

Please list all previous surgeries: _____

_____

_____

Have you experienced any complications from surgery? Y / N _____

Please list all **medications** that you take:

_____

_____

_____

_____

_____

Please list all medical **allergies:**

_____

_____

_____

_____

_____

Tobacco use:
Current, Former, Never (circle)
# of years _____, packs per day _____

Alcohol use:
Current, Former, Never (circle)
# of years_____, social / regular # per day _____

Recreational Drug use:
Current, Former, Never (circle)
# of years _____

Do you have a family history of: (circle) heart disease, high blood pressure, diabetes, thyroid problems, anemia, asthma, arthritis, TB, hernias, gallbladder disease.

Do you have a family history of cancer? Y / N What kind of cancers?_____

Do you have any other disease that runs in your family?_____

Have you or do you experience any of the following symptoms or problems? (circle)

1. Seizures, loss of consciousness, chronic headaches, hearing loss, dizziness, inner ear problems, change in vision, sinus problems, nose bleeds, sore throats, sores in mouth, chronic neck pain.
2. Shortness of breath, cough, wheezing, pneumonia or bronchitis. Chest pain, palpitations, ankle swelling, shortness of breath while sleeping.
3. Change in appetite, abdominal pain, nausea, vomiting, change in bowel habits, diarrhea, constipation, blood in stools, black colored stools, incontinence of stool.
4. Difficulty or pain in urination, blood in urine, prostate problems, kidney stones, incontinence of urine, sexually transmitted disease.
5. Chronic back pain, joint problems, muscle pain or weakness, trouble with ambulation.
6. Chronic fevers or chills, night sweats, unexplained weight loss or weight gain.
7. **Female patients only.** Vaginal discharge or abnormal bleeding, pelvic pain, irregular or abnormally painful periods. # of pregnancies _____, # of deliveries _____, date of last menstrual period _____, age of menstruation _____, age of first live birth _____.