UPSTATE SURGICAL GROUP, P.C.

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PATIENT INFO

PATIENT NAME: _____

DOB: _____ AGE: _____

HEIGHT: _____ WEIGHT: _____

WHAT ARE YOUR CONCERNS FOR TODAY'S VISIT?

_____
_____
_____
_____

REFERRING PHYSICIAN INFO

REFERRING PHYSICIAN (NAME, ADDRESS, PHONE)

_____
_____
_____

PRIMARY CARE PHYSICIAN (NAME, ADDRESS, PHONE)

_____
_____
_____

PATIENT MEDICAL HISTORY

(PLEASE CHECK APPROPRIATE BOX IF YOU OR YOU FAMILY HAVE ANY OF THE FOLLOWING)

	YOU	YOUR FAMILY	RELATIONSHIP (IF FAMILY)
ANESTHESIA PROBLEMS	☐	☐	
BLEEDING PROBLEMS	☐	☐	
BIRTH DEFECTS	☐	☐	
DIABETES	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
THYROID PROBLEMS	☐	☐	
HEARING PROBLEMS	☐	☐	
TUBERCULOSIS	☐	☐	
HEART DISEASE	☐	☐	
RESPIRATORY PROBLEMS	☐	☐	
STOMACH OR INTESTINAL PROBLEMS	☐	☐	
VISION PROBLEMS	☐	☐	
KIDNEY DISORDERS	☐	☐	
NEUROLOGICAL PROBLEMS	☐	☐	
PSYCHOLOGICAL PROBLEMS	☐	☐	
CANCER	☐	☐	

OTHER MEDICAL DIAGNOSIS _____

SCREENINGS

DATE OF LAST COLONOSCOPY:

_____

HOSPITALIZATIONS / SURGERIES

PLEASE LIST ANY HOSPITALIZATIONS/SURGERIES AND DATE

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

	YES	NO	
DO YOU SMOKE: IF SO, HOW MUCH:	☐	☐	_____
IF NO, DID YOU EVER SMOKE?	☐	☐	_____
DO YOU DRINK ALCOHOL?	☐	☐	_____
IF SO, HOW MUCH DO YOU DRINK?	☐	☐	_____

WHAT IS YOUR OCCUPATION? _____

MARITAL STATUS: _____

LIST ANY STREET DRUGS YOU USE _____

FAMILY HISTORY

		AGE	HEALTH	AGE/REASON OF DEATH (if applicable)
	SPOUSE			
	FATHER			
	MOTHER			
SIBLINGS	BROTHER / SISTER			
(circle one)	BROTHER / SISTER			
	BROTHER / SISTER			
CHILDREN	DAUGHTER / SON			
(circle one)	DAUGHTER / SON			
	DAUGHTER / SON			
	DAUGHTER / SON			

PATIENT NAME: _____ DOB: _____

MEN

Are you sexually active? _____
difficulty having or maintaining erection? _____
known prostate problems? _____

WOMEN

are you sexually active? _____
age at birth of 1st child? _____
number of pregnancies: _____
number of children: _____
did you breastfeed? _____
last pap smear? _____
result: _____

last mammogram: _____
result: _____
age when menstrual period began: _____
irregular periods? _____
painful cramps w/periods? _____
menopause (age) _____
lumps in breast? _____
past breast biopsies _____

Who do you see for your yearly breast exams? _____

results: (circle one) cancerous / pre-cancerous / negative

Do you take or have you ever taken:
Female replacement hormones? _____
Birth control pills? _____
Norplant? _____

Do you have a family history (siblings, mother's family, father's family) of: Age at diagnosis
breast cancer? yes no Who? _____ _____
ovarian cancer? yes no Who? _____ _____
colon cancer? yes no Who? _____ _____

Are you of Ashkenazi Jewish Descent? yes no

Have you or anyone in your family ever been genetically tested? yes no Who? _____
Results: _____

PLEASE CIRCLE ANY SYMPTOMS YOU ARE CURRENTLY HAVING:

BREAST ISSUES

breast implants: saline or silicone
discharge
lump
pain
rash

EAR, NOSE AND THROAT

dizziness
ear noises
hearing loss
nasal congestion
problem snoring, apnea
sense of smell
sinus pressure or pain
speech or voice
throat dryness/itching
throat pain

GASTROINTESTINAL

constipation
dark, tarry or bloody stools
diarrhea
difficulty swallowing
heartburn
loss of bowel control
nausea or vomiting
stomach pain

GENERAL

chills
daytime sleepiness
fatigue
fever
night sweats
weight loss or gain

GENITO-URINARY

bloody or dark brown urine
difficulty completely emptying bladder
difficulty starting urination
frequent urination
loss of bladder control
painful urination
waking up at chest pain

ENDOCRINE

feeling colder than others
feeling warmer than others

HEMATOLOGIC/LYMPHATIC

bleeding problems
easy bruising
swollen glands

MUSCULO/SKELETAL

joint aches
trouble walking

NEURO

headache
passing out

PSYCHIATRIC

depression
mental health problems

RESPIRATORY/CARDIAC

chest pain
cough
coughing up blood
palpitations
shortness of breath
wheezing

SKIN

growing/changing mole
hives
itching
lumps under skin
rash
skin or hair changes

PATIENT NAME: _____ DOB: _____

PHARMACY

PHARMACY NAME: _____ PHARMACY PHONE# _____

I, _____ give consent to retrieve and use my medication history from Surescripts.
signature required

MEDICATIONS:

ARE YOU CURRENTLY TAKING A BLOOD THINNER? _____ IF YES, WHAT TYPE? _____

LIST ALL THE MEDICATIONS YOU ARE TAKING. INCLUDE OVER-THE-COUNTER MEDICATIONS, VITAMINS, AND MEDICATIONS TAKEN "AS NEEDED"

	NAME OF MEDICATION	DOSE	FREQUENCY TAKEN	REASON FOR TAKING
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ALLERGIES:

LIST ALL MEDICATION ALLERGIES, AND DESCRIBE YOUR ALLERGIC REACTION

1. _____
2. _____
3. _____
4. _____
5. _____

OTHER

PLEASE CHECK HERE IF, FOR RELIGIOUS REASONS, YOU WILL NOT TAKE BLOOD PRODUCTS _____