Office Visit Information *(General Surgery)*

Amarillo Surgical Group Doctor:_____ Date:_____

Patient's Information

Name: Last_____ First_____Middle_____
Social Security #:_____ Date of Birth:_____ Age_____
Gender: [Male / Female] Marital Status: [Single / Married / Divorced / Widowed]
Home address:
Street:_____
City:_____ State:_____ Zip:_____
Phone #'s: Home:_____ Work:_____ Other:_____
Employer:_____Occupation:_____

Additional Party to Contact

Name: Last_____ First_____Middle_____
Phone #'s: Home:_____ Work:_____ Other:_____
Relationship to patient:_____

Responsible Party's Information (if different from patient)

Name: Last_____ First_____Middle_____
Social Security #:_____ Date of Birth:_____
Home address:
Street:_____
City:_____ State:_____ Zip:_____
Phone #'s: Home:_____ Work:_____ Other:_____
Employer:_____Occupation:_____
Relationship to patient:_____

Other Physicians

Did another physician refer you to our office? Name:_____
Who is your primary / family physician? Name:_____
Is there another physician to whom we should send records pertaining to your visit?
Name:_____

Workman's Compensation

If your illness is related to an on the job injury, please complete an insurance information form.

Consent to Release of Information

I authorize the release of any medical information necessary to process a claim on my behalf and request payment of any insurance benefits to Amarillo Surgical Group or myself.
X_____
Signature of patient or guardian

1. **Why are you being seen in this office?**

_____

_____

2. **List any diagnostic tests you may have had related to your current condition (for example: CT scan, mammogram, x-rays, gallbladder tests, sonogram, arteriogram, etc.):**

Type of Test	Institution Where Performed	Date of Test

3. **List any other medical problems and/or previous illnesses such as diabetes, high blood pressure, stroke, etc.:**

_____

_____

_____

4. **List any previous operations:**

Type of Operation	Institution Where Performed	Date of Op

5. **List any previous major injuries:**

Type of Injury	Institution Where Treated	Date of Injury

6. **Are you allergic to any medications: Yes / No -- if yes, please list:**

_____

_____

7. **List current medications (or attach your own list). If you are being seen in the hospital, list medications taken prior to admission. Please include over-the-counter medications, such as aspirin, as well as prescription drugs. Also include any vitamin, mineral, or herbal supplements such as ginseng:**

Name of Medication	Size of Dose	Frequency of Dosage (for example: twice a day)

8. Complete the chart below with family history:

Check Box if Ever Present, Circle Check for Cause of Death	Age		Stroke	Diabetes	Hypertension	Heart Disease	Tuberculosis	Alcoholism	Jaundice	Bleeder	Obesity	Gout	Asthma	Cancer	Mental Illness		
	If Living	At Death															
Father																	
Mother																	
List siblings, children below:																	

9. What is your occupation?

_____

10. What is your highest level of education?
Grade Level_____/ High School / College / Post Graduate

11. Have you ever smoked on a regular basis? [Yes / No] If yes, please describe type, amount, how long, if stopped, when:

_____

12. Do you drink alcohol? [Yes / No] If yes, please describe:

_____

13. Do you take any regular exercise? [Yes / No] If yes, please describe:

_____

14. Do you take any special diet? [Yes / No] If yes, please describe:

_____

15. List other persons living in your home and their relationship to you:

_____

_____

Review of Systems

1. Constitutional Symptoms

Have you had any of the following?

Recent weight loss or gain	Yes / No
Poor appetite	Yes / No
Weakness or fatigue	Yes / No
Fever, chills or night sweats	Yes / No
Difficulty sleeping	Yes / No
Dizziness, lightheadedness or fainting spells	Yes / No
Other generalized problem	Yes / No

Please explain:

2. Eyes

Have you had any of the following?

Blurred vision	Yes / No
Blind spots	Yes / No
Spots before your eyes	Yes / No
Red, itching, burning, or dry eyes	Yes / No
Excessive tearing	Yes / No
Eye pain	Yes / No
Glaucoma	Yes / No
Other eye problems	Yes / No

Please explain:

3. Ears, Nose, Mouth, Throat

Have you had any problems with your ears, nose, mouth, throat or any of the following:

Hearing difficulty	Yes / No
Ringing in Ears	Yes / No
Ear pain	Yes / No
Other ear problem	Yes / No
Decreased smell	Yes / No
Nasal Bleeding, Discharge or Obstruction	Yes / No
Other nasal problem	Yes / No
Bleeding gums	Yes / No
Dental problems	Yes / No
Other oral problem	Yes / No
Sore throat	Yes / No
Difficulty swallowing	Yes / No
Hoarseness or change in voice	Yes / No
Other throat problem	Yes / No

Please explain:

4. Cardiovascular

Have you had any heart or blood vessel problems or any of the following:

Heart attack	Yes / No
Balloon angioplasty, stent or other interventional cardiology procedure	Yes / No
Congestive heart failure (fluid in lungs)	Yes / No
Chest pain / pressure at rest or with exertion	Yes / No
Shortness of breath at rest or with exertion	Yes / No
Awaking at night short of breath	Yes / No
Difficulty breathing when lying flat	Yes / No
Swelling of feet, ankles, or legs	Yes / No
Palpitations, skipped beats	Yes / No
Heart rhythm problems or pacemaker	Yes / No
Heart murmur	Yes / No
Phlebitis, varicose veins	Yes / No
Elevated cholesterol or triglycerides	Yes / No
Other cardiovascular problem	Yes / No

Please explain:

5. Respiratory

Have you had any respiratory difficulty or any of the following:

Cough	Yes / No
Coughing up sputum or blood	Yes / No
Chest pain with breathing	Yes / No
Wheezing	Yes / No
Exposure to tuberculosis	Yes / No
Other respiratory problem	Yes / No

Please explain:

6. Gastrointestinal

Have you had any gastrointestinal problems or any of the following:

Nausea or vomiting	Yes / No
Difficulty swallowing	Yes / No
Heartburn	
Vomiting blood	Yes / No
Black stools or blood in bowel movement	Yes / No
Change in bowel habits	Yes / No
Diarrhea, constipation	Yes / No
Abdominal pain	Yes / No
Other gastrointestinal problem	Yes / No

Please explain:

7. Genitourinary

Have You Had Any Genitourinary Problems Or Any Of The Following:

Painful or frequent urination	Yes / No
Difficulty starting urination	Yes / No
Awaking at night to urinate	Yes / No
Incontinence	Yes / No
Blood in urine	Yes / No
Sexual problems	Yes / No
Other genitourinary problem	Yes / No

Please explain:

8. Musculoskeletal

Have you had any musculoskeletal problems or any of the following:

Neck stiffness, pain, or decreased range of motion	Yes / No
Other Neck Problem	Yes / No
Muscle pains or aches	Yes / No
Muscle weakness	Yes / No
Painful, red, stiff, or swollen joints	Yes / No
Other musculoskeletal problem	Yes / No

Please explain:

9. Integumentary (Skin And/Or Breasts)

Have you had any problems with your skin, breasts or any of the following?

Change In Skin Color	Yes / No
Itching	Yes / No
Rash	Yes / No
Hair Change	Yes / No
Nail Change	Yes / No
Other Skin Problem	Yes / No
Nipple Discharge	Yes / No
Breast Lump or Pain	Yes / No
Other Breast Problem	Yes / No

Please explain:

10. Neurological / Psychiatric

Have you had any neurologic or psychiatric problems or any of the following:

Difficulty with memory	Yes / No
Headaches	Yes / No
Difficulty sleeping	Yes / No
Stroke	Yes / No
Episodes of weakness or difficult /slurred speech	Yes / No
Seizures	Yes / No
Numbness or tingling	Yes / No
Difficulty with balance	Yes / No
Loss of bladder or bowel control	Yes / No
Nervousness	Yes / No
Depression	Yes / No
Hallucinations	Yes / No
Nervous breakdown	Yes / No
Other neurologic or psychiatric problem	Yes / No

Please explain:

11. Endocrine

Have you had any problems with your endocrine systems or any of the following?

Heat or cold intolerance	Yes / No
Diabetes	Yes / No
Thyroid problem	Yes / No
Other endocrine or gland problem	Yes / No

Please explain:

12. Hematologic / Lymphatics

Do you have any problems with your blood or lymphatic systems or any of the following:

Anemia	Yes / No
Easy bruising or other bleeding abnormality	Yes / No
Swollen lymph nodes	Yes / No
Other blood of lymph system problem	Yes / No

Please explain:

13. Cerebrovascular

Have you had any of the following problems?

Temporary blindness in one eye	Yes / No
Blurred vision in one eye	Yes / No
Numbness or tingling of face, 1 arm or 1 leg	Yes / No
Temporary weakness of one side of face, 1 arm or 1 leg	Yes /No
Dizziness	Yes /No
Fainting	Yes / No
Temporary paralysis of both legs	Yes /No

14. Peripheral Vascular

Have you had any of the following problems?	
Cramping or tiredness of legs that occurs at about the same distance while walking	Yes / No
If Yes, how far can you walk before these symptoms occur?	
If these symptoms of tiredness or cramping occur, are they relieved by standing still and resting?	Yes / No
If so, how long does it take for the symptoms to disappear?	
Do you have to sit down for the symptoms to disappear?	Yes / No
If so, how long does it take for the symptoms to disappear?	
Do you have numbness or burning pain in your toes after going to bed at night?	Yes / No
If so, does standing up or walking relieve these symptoms?	Yes / No

15. Breast Problems (females only)

At what age did you first begin to menstruate?	
At what age did you stop menstruating?	
How many children have you had?	
Did you nurse your children?	Yes / No
If so, how long? (specify for each child)	
.	
Do you take female hormones?	Yes / No
Do you have any family members with breast cancer?	Yes / No
If yes, specify relationship i.e. maternal or paternal and age of diagnosis of breast cancer if possible	
Have you had previous breast surgery?	Yes / No