PARAGON SURGICAL SPECIALISTS

DATE_____

Name _____ Birth Date_____

Male_____ Female_____ Primary Care Physician_____

Height_____ Weight_____ Referring Doctor (if different from Primary) _____

Language Preference English _____ Local Pharmacy_____

Advanced Directives / Living Will: Yes / No - Type_____

Race (Circle One): American Indian or Alaska Native; Asian; Black or African American; more than one race; Native Hawaiian; Other Pacific Islander; White

Ethnicity (Circle One): Hispanic / Latino Not Hispanic / Latino

ALLERGIES:

Medication Allergies_____

Contactants:	Adhesive Tape	Yes	No
	Betadine	Yes	No
	Latex	Yes	No
Foods:	Shellfish	Yes	No

MEDICATIONS:

Please List Current Medications: (include dosage and frequency) _____

_____

HISTORY OF PRESENT ILLNESS

Reason For Today's Visit: _____

CURRENT COMPLAINTS:

General			Gastrointestinal			Neurological:		
Fatigue	Yes	No	Abdominal Pain	Yes	No	Headache	Yes	No
Fever	Yes	No	Bloody Stool	Yes	No	Seizures	Yes	No
Weight Gain Greater than 10 lbs	Yes	No	Constipation	Yes	No	Stroke	Yes	No
Weight Loss Greater than 10 lbs	Yes	No	Diarrhea	Yes	No	Weakness in extremities	Yes	No
Skin			Difficulty Swallowing	Yes	No			
Hair Loss	Yes	No	Heartburn	Yes	No	Psychiatric:		
Rash	Yes	No	Indigestion	Yes	No	Anxiety	Yes	No
Skin Color Changes	Yes	No	Nausea	Yes	No	Depression	Yes	No
HEENT			Vomiting	Yes	No	Panic Attacks	Yes	No
Blurred Vision	Yes	No						
Head Injury	Yes	No	Genitourinary:			Endocrine:		
Visual Loss	Yes	No	Male:			Excessive Thirst	Yes	No
Hearing Loss	Yes	No	Blood in urine	Yes	No	Thyroid Problems	Yes	No
Hoarseness	Yes	No	Change in urinary stream	Yes	No			
Sore Throat	Yes	No	Incontinence	Yes	No	Hematology:		
Neck			Painful Urination	Yes	No	Blood Clots	Yes	No
Neck Mass	Yes	No	Testicular mass	Yes	No	Easy Bruising	Yes	No
Swollen Glands	Yes	No	Testicular pain	Yes	No	Enlarged Lymph Nodes	Yes	No
Respiratory			Female:			Prolonged Bleeding	Yes	No
Chronic Cough	Yes	No	Are you pregnant	Yes	No			
Difficulty Breathing	Yes	No	Blood in Urine	Yes	No			
Wheezing	Yes	No	Discharge	Yes	No			
Breast			Incontinence	Yes	No			
Breast Mass	Yes	No	Painful Urination	Yes	No			
Breast Pain	Yes	No	Vaginal Bleeding	Yes	No			
Breast Swelling	Yes	No						
Nipple Discharge	Yes	No	Musculoskeletal:					
Skin Changes On the Breast	Yes	No	Back Pain	Yes	No			
Cardiovascular			Joint Pain	Yes	No			
Chest Pain	Yes	No	Joint Stiffness	Yes	No			
Palpitation	Yes	No	Joint Swelling	Yes	No			
Swelling of Extremities	Yes	No	Muscle Weakness	Yes	No			

(Continued)

PAST MEDICAL HISTORY:

Arthritis Yes No
Asthma Yes No
Bleeding Tendency Yes No
If yes what type?_____
Blood Clots If yes, Legs Yes No
Lung Yes No
Cancer Yes No
If yes what type?_____
Radiation Yes No
Chemotherapy Yes No
COPD (Cardiopulmonary Disease) Yes No
Diabetes Yes No
Heart Attack Yes No
Hepatitis Yes No
High Blood Pressure Yes No
High Cholesterol Yes No
HIV/AIDS Yes No
Kidney Failure Yes No
If yes on Dialysis? Yes No
Malignant Hyperthermia Yes No
MRSA Yes No
Seizure Disorder Yes No
Stroke Yes No

SOCIAL HISTORY:

Tobacco Use (Circle One):

Never Smoked Smoker - amount _____
Previous Smoker Other Type - _____

Drug Use: Yes No

Alcohol Use: Yes No

HEALTH MAINTENANCE:

Last Mammogram:

Date/Years ago _____
Never

Last Colonoscopy:

Date/Years ago _____
Never

HOW WOULD YOU LIKE TO BE CONTACED FOR:

Appointment Reminders or Changes:

Phone ___ Text Message ___ Email ___

Billing / Insurance Questions or Statements:

Phone ___ Text Message ___ Email ___

PAST SURGICAL HISTORY:

YEAR

Abdominal
- Appendectomy Yes No
- Bowel Resection Yes No
- Gallbladder Removal Yes No
- Liver Resection Yes No
- Pancreatic Resection Yes No

ENT
- Sinus Surgery Yes No
- Tonsillectomy Yes No
- Tracheostomy Yes No

Breast
- Lumpectomy / Mastectomy R or L

GYN
- Hysterectomy Yes No
- If yes, what type_____
- Removal of Tubes and Ovaries Yes No

Heart
- Pace Maker Yes No
- Bypass Grafts Yes No
- Surgery / Stent Placement Yes No
- Valve Replacement Yes No

Hernia R or L
- Groin / Inguinal Yes No
- Hiatal Yes No
- Incisional Yes No
- Naval / Umbilical Yes No

OB
- C-section Yes No
- Tubal Ligation Yes No

Orthopedic
- Any Metal Rods/Plates Yes No
- Total Hip Yes No
- Total Knee Yes No
- Total Shoulder Yes No

Thoracic
- Esophageal Resection Yes No
- Lung Resection Yes No

Vascular
- Aneurysm
  - Abdominal Aorta Yes No
  - Intracranial Yes No
  - Thoracic Aorta Yes No
- Leg Bypass Yes No
- Carotid Artery Surgery Yes No

Other (Please List) _____
_____

FAMILY HISTORY:

Cancer: Relationship
- Breast Yes No _____
- Colon Yes No _____
- Lung Yes No _____
- Melanoma Yes No _____
- Skin Yes No _____
- Thyroid Yes No _____
- Ovarian Yes No _____
- Pancreatic Yes No _____
- Other _____

COPD (Cardiopulmonary Disease) Yes No _____
Diabetes Yes No _____
Heart Disease Yes No _____
High Blood Pressure Yes No _____
High Cholesterol Yes No _____
Kidney Failure Yes No _____
Seizure Disorder Yes No _____
Stroke Yes No _____
Blood Vessel Disease Yes No _____