Arrow Surgical Associates, P.C.

Andrew P. Smith, MD • V. Joe Deka, MD FACS

Name: ______________________________ DOB: __________ Date: ______________

Email: ______________________________

Primary Care Doctor: ______________________ Referred By: ______________________

Please list in order of importance, the present **health concerns**, **symptoms** or **problems** which bring you to our office today:

____

____

____

Age: __________ Height: __________ Approximate Weight: ______________

MEDICAL ALLERGIES:	**REACTION:**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

CURRENT MEDICATIONS:	**DOSAGE:**	**FREQUENCY** (how often):
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________

PRIOR SURGERIES:	**DATE**(s)
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

CURRENT MEDICAL PROBLEMS: (i.e. high blood pressure, diabetes)

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Name: ______________________________ DOB: ____________ Date: ________________

****Has any BLOOD RELATIVE had any of the following?** If **YES**, their relationship to you:

	YES	NO	If YES, their relationship to you
High Blood Pressure	☐	☐	______________________
Heart Disease	☐	☐	______________________
Stroke	☐	☐	______________________
Diabetes	☐	☐	______________________
Bleeding Problems	☐	☐	______________________
Anemia	☐	☐	______________________
Asthma	☐	☐	______________________
Tuberculosis	☐	☐	______________________
Thyroid Disorder	☐	☐	______________________
Hormone Problems	☐	☐	______________________
Kidney Problems	☐	☐	______________________
Hepatitis	☐	☐	______________________
Gallbladder Disease	☐	☐	______________________
Colon Cancer	☐	☐	______________________
Breast Cancer	☐	☐	______________________
Other (_______)Cancer	☐	☐	______________________

FEMALE PATIENTS ONLY:

At what age did you begin menstruation? ______________________

How many pregnancies have you had? ______________________

Live births? ______________________

Your age at time of first pregnancy? ______________________

Are you still menstruating? ______________________

If no, at what age did you stop menstruating? ______________________

Date of last mammogram? ______________________

Where was your mammogram done? ______________________

Do you have any of the following problems?

	Right	Left	How Long?
Breast Lump	☐	☐	______________________
Breast Pain	☐	☐	______________________
Breast Skin Changes	☐	☐	______________________
Nipple Discharge	☐	☐	______________________
Inverted Nipple	☐	☐	______________________
Skin Dimpling	☐	☐	______________________

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Do you **now have or have you RECENTLY had:**

	YES	NO
fever	☐	☐
night sweats	☐	☐
significant weight change	☐	☐
(____lbs up or down)		
dry eyes	☐	☐
irritation	☐	☐
vision change	☐	☐
difficulty hearing	☐	☐
ear pain	☐	☐
frequent nosebleeds	☐	☐
nose/sinus problems	☐	☐
sore throat	☐	☐
bleeding gums	☐	☐
snoring	☐	☐
dry mouth	☐	☐
mouth ulcers	☐	☐
oral abnormalities	☐	☐
teeth problems	☐	☐
chest pain	☐	☐
arm pain on exertion	☐	☐
shortness of breath (walking)	☐	☐
shortness of breath (lying down)	☐	☐
heart palpitations	☐	☐
known heart murmur	☐	☐
light- headed on standing	☐	☐
cough	☐	☐
wheezing	☐	☐
coughing up blood	☐	☐
sleep apnea	☐	☐

	YES	NO
abdominal pain	☐	☐
vomiting	☐	☐
diarrhea	☐	☐
(___x's per day)		
vomiting blood	☐	☐
change in appetite	☐	☐
black or tarry stools	☐	☐
constipation	☐	☐
hemorrhoids	☐	☐
gas	☐	☐
bloating	☐	☐
indigestion	☐	☐
heartburn	☐	☐
incontinence	☐	☐
difficulty urinating	☐	☐
hematuria (blood in urine)	☐	☐
increased void frequency	☐	☐
muscle aches	☐	☐
muscle weakness	☐	☐
joint pain	☐	☐
back pain	☐	☐
swelling in the extremities	☐	☐
abnormal mole	☐	☐
jaundice	☐	☐
rashes	☐	☐
itching	☐	☐
dry skin	☐	☐
growths/lesions	☐	☐

	YES	NO
loss of consciousness	☐	☐
weakness	☐	☐
numbness	☐	☐
seizures	☐	☐
dizziness	☐	☐
headaches	☐	☐
migraines	☐	☐
restless legs	☐	☐
depression	☐	☐
sleep disturbances	☐	☐
restless sleep	☐	☐
feeling safe in relationship	☐	☐
alcohol abuse	☐	☐
fatigue	☐	☐
increased thirst	☐	☐
hair loss	☐	☐
increased hair growth	☐	☐
cold intolerance	☐	☐
swollen glands	☐	☐
easy bruising	☐	☐
excessive bleeding	☐	☐
runny nose	☐	☐
sinus pressure	☐	☐
itching	☐	☐
hives	☐	☐
frequent sneezing	☐	☐

NOTES:______________________________

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Habits:

Tobacco (type and amount per day): ______________________________

If former smoker, date quit: ______________________________

Alcohol (amount per week): ______________________________

Caffeine (amount per day): ______________________________

Street drugs (type and amount per day): ______________________________

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