# Watauga Surgical Group, P.A.

Name:_________________________________ DOB: _______________ Date:_______________________

## Past Medical History
**Circle Yes or No**

| Have You Ever Had: | | | Year |
|---|---|---|---|
| Anemia | Yes | No | |
| Arthritis | Yes | No | |
| Asthma | Yes | No | |
| Blood Clot/ DVT/ PE | Yes | No | |
| Blood Transfusion | Yes | No | |
| Bronchitis | Yes | No | |
| Cancer | Yes | No | |
| Diabetes | Yes | No | |
| Emphysema | Yes | No | |
| Fibromyalgia | Yes | No | |
| Heart Attack | Yes | No | |
| Heart Disease | Yes | No | |
| Hepatitis | Yes | No | |
| High Blood Pressure | Yes | No | |
| Hx of MRSA | Yes | No | |
| Kidney Disease | Yes | No | |
| Pneumonia | Yes | No | |
| Reflux | Yes | No | |
| Stroke | Yes | No | |
| Ulcer | Yes | No | |
| Other | Yes | No | |

| Operations | | | Year |
|---|---|---|---|
| Appendix | Yes | No | |
| Breast | Yes | No | |
| Colon | Yes | No | |
| Gall Bladder | Yes | No | |
| Heart | Yes | No | |
| Hernia | Yes | No | |
| Prostate | Yes | No | |
| Stomach | Yes | No | |
| Thyroid | Yes | No | |
| Uterus/Ovary | Yes | No | |
| Other | Yes | No | |

___________________

**Family History-Has any blood relative had any of the following. Circle "Yes" or "No", If so, what relationship**

| | | | |
|---|---|---|---|
| Cancer | Yes | No | ____________________ |
| Colon Polyps | Yes | No | ____________________ |
| Diabetes | Yes | No | ____________________ |
| Heart Disease | Yes | No | ____________________ |
| Thyroid Trouble | Yes | No | ____________________ |

**Medications, Including over-the-counter medications and vitamin supplements**

| Medication Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |

**PHARMACY NAME** ________________________________

**ADDRESS** ________________________________________

**PHONE NO.** ______________________________________

## IMMUNIZATIONS

| | | |
|---|---|---|
| Smallpox | Yes | No |
| Tetanus | Yes | No |
| Polio Shots | Yes | No |
| Polio Oral | Yes | No |
| Other | Yes | No |

## SOCIAL HISTORY

| | | |
|---|---|---|
| Smoking | Yes | No |
| Snuff | Yes | No |
| Chewing Tobacco | Yes | No |
| Alcohol | Yes | No |
| Drugs | Yes | No |

| MEDICATION ALLERGY | REACTION |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Latex Allergy** ☐ **Yes** ☐ **No**

# Watauga Surgical Group, P.A.

**Patient Name:**_____________________________ **DOB:** ____________ **Date:**________________

**Primary Care Physician** __________________________
**Referring Physician** __________________________

**Have you recently had the following: Circle Yes or No; if in doubt, leave blank.**

## REVIEW OF SYSTEMS

**GENERAL**

| | | |
|---|---|---|
| Fever | Yes | No |
| Weakness | Yes | No |
| Night Sweats | Yes | No |

**EYES**

| | | |
|---|---|---|
| Vision Changes | Yes | No |
| Double vision | Yes | No |

**EARS, NOSE, THROAT**

| | | |
|---|---|---|
| Post nasal drip | Yes | No |
| Hoarsness | Yes | No |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| Chest Pain | Yes | No |
| Palpitations | Yes | No |

**RESPIRATORY**

| | | |
|---|---|---|
| Cough | Yes | No |
| Hemopytsis (coughing up blood) | Yes | No |
| Wheezing | Yes | No |
| Shortness of breath | Yes | No |
| Difficulty breathing while lying down | Yes | No |
| Phlegm | Yes | No |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Abdominal pain | Yes | No |
| Nausea | Yes | No |
| Vomiting | Yes | No |
| Diarrhea | Yes | No |
| Constipation | Yes | No |
| Change in Bowel Habits | Yes | No |
| Tarry (black) stools | Yes | No |
| Rectal Bleeding | Yes | No |
| Gas/Bloating | Yes | No |
| Indigestion/Heartburn | Yes | No |
| Dysphagia (difficulty swallowing) | Yes | No |
| Changes in appetite | Yes | No |
| Vomiting blood | Yes | No |

**GENITOURINARY**

| | | |
|---|---|---|
| Dysuria (painful urination) | Yes | No |
| Hematuria (blood in urine) | Yes | No |

**VASCULAR**

| | | |
|---|---|---|
| Varicose veins R/L | Yes | No |
| Leg swelling R/L | Yes | No |
| Pain in calf when walking R/L | Yes | No |
| Pain in toes at night R/L | Yes | No |

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Muscle weakness | Yes | No |
| Back pain | Yes | No |

**DERMATOLOGY**

| | | |
|---|---|---|
| Jaundice | Yes | No |
| Rash | Yes | No |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Fainting | Yes | No |
| Paralysis | Yes | No |
| Frequent headaches | Yes | No |

**HEMATOLOGY**

| | | |
|---|---|---|
| Abnormal brusing | Yes | No |
| Excessive bleeding | Yes | No |

**Psychiatric**

| | | |
|---|---|---|
| Depression | Yes | No |
| Anxiety | Yes | No |

**ENDOCRINIOLOGY**

| | | |
|---|---|---|
| Cold intolerance | Yes | No |
| Heat intolerance | Yes | No |
| Weight Gain | Yes | No |
| Weight loss | Yes | No |

**TUBERCULOSIS**

Have you ever had Tuberculosis Yes No If yes, were you treated___________________________

Have you ever had a positive PPD Test Yes No

Have you ever been diagnosed with an infectious disease? Yes No
If so, what disease? _____________________________________________