CITY SURGICAL CARE

PATIENT MEDICAL HISTORY

Flagship Office / Corporate Office:
555 Passaic Ave. Suite 10,
West Caldwell, NJ 07006
P 973-227-0680 | **F** 973-227-0736

Name_____ Age:_____ Birthdate:_____ Sex: ☐ Female ☐ Male

Address_____ Status **(OPTIONAL):** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

City_____ State_____ Zip_____ If married, spouse's name:_____

Home Phone: _____ Mobile/Work Phone: _____ Email:_____

Preferred Contact Method:_____ Occupation:_____

How did you hear about us? ☐ Web ☐ Friend/Patient ☐ MD:_____ ☐ Other:_____

Are you interested in writing an online review? ☐ Yes ☐ No **Height:** _____ **ft/inches** **Weight:**_____**lbs**

Primary Care Physician: _____ ☐ None

Office Tel#: _____ Fax:_____

Address: _____

Referring Physician: _____ ☐ None

Office Tel#:_____ Fax:_____

Address: _____

Allergies to Medications, X-Ray Dyes, or other substances ☐ No ☐ Yes *(if yes, please list name of medicine(s) & the type of reaction)*

☐ Penicillin (PCN) ☐ Ceph ☐ Sulf ☐ Latex ☐ IV Contrast ☐ Other:_____

☐ Anaphylaxis? (If so reaction?):_____

Past Medical History & Review of Symptoms *Please check if you have had any problems with or are presently experiencing any of the following:*

☐ **Heart Disease**	☐ **Frequent urination**	☐ **Arthritis**	☐ **Thyroid disease**	☐ **Celiac or IBS**	☐ **Colitis**
☐ **Arterial Disease**	☐ **Gall bladder disease**	☐ **Back Pain**	☐ **Chest pain/chest tightness**	☐ **Indigestion**	☐ **Gout**
☐ **DVT**	☐ **Kidney stones**	☐ **Sciatica**	☐ **Persistent cough**	☐ **Constipation**	☐ **Ulcers**
☐ **Palpitations**	☐ **Cancer**	☐ **Fibroids**	☐ **Asthma**	☐ **Hepatitis or jaundice**	☐ **Skin diseases**
☐ **Lightheadedness**	☐ **Arm swelling or pain**	☐ **Blood disorders**	☐ **Bronchitis**	☐ **Headaches**	☐ **Venereal diseases**
☐ **Lipedema**	☐ **High blood pressure**	☐ **Anemia**	☐ **Pneumonia**	☐ **Depression/Anxiety**	☐ **Rheumatic fever**
☐ **Lymphedema**	☐ **Leg Pain**	☐ **Sleep Apnea**	☐ **Shortness of breath**	☐ **Nausea/Vomiting**	☐ **Hay fever**
☐ **Swollen ankles**	☐ **Leg swelling** (during travel or pregnancy)	☐ **Diabetes**	☐ **Unexplained weight gain/loss**	☐ **Drug/Alcohol abuse**	☐ **TB**

Any permanent implants? ☐ No ☐ Yes *if yes, what type:* ☐ Mesh ☐ Spine ☐ Breast ☐ Heart ☐ Joint ☐ Other: _____

Please list and supply the dates of previous operations:

☐ Other Gynecologic surgery:_____ ☐ Blood Transfusion:_____

☐ Other Cancer surgery:_____ ☐ Spine surgery:_____

☐ C-Sections:_____ ☐ Hysterectomy:_____

☐ Gallbladder surgery:_____ ☐ Vascular surgery: ☐ Vein ablation ☐ Stripping ☐ Other:_____

☐ Fibroid surgery: _____ ☐ Heart surgery: ☐ Bypass ☐ Valve ☐ Other:_____

☐ Breast surgery: ☐ Cancer ☐ Implant ☐ Other:_____ ☐ Other:_____

Family History *Has any member of your family (including parents, grandparents & siblings) ever had the following?*

ILLNESS: ☐ Cancer: ☐ Breast ☐ Colon ☐ Skin ☐ Prostate ☐ Testicle ☐ Ovarian ☐ Uterine ☐ Other:_____

☐ Heart Disease ☐ Stroke ☐ Hypertension ☐ Diabetes ☐ Glaucoma ☐ Bleeding Disease (or clot disorder) ☐ Drug or Alcohol addiction

☐ Varicose Veins ☐ Venous Disease ☐ Arterial Disease ☐ Mental Disease (anxiety, depression, etc.) ☐ Other: _____

What family member was diagnosed with the illness checked off:_____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc - Please list medication names.)	**OTHER MEDS.**	**DOSE**
☐ Anti-Anxiety Meds:_____		
☐ Anti-Seizure Meds:_____		
☐ Anti-Fungals Meds:_____		
☐ Oral Contraceptives:_____		
☐ Blood Thinners:_____		
☐ Blood Pressure Meds:_____		
☐ Mood Altering Meds:_____		

Pharmacy (Name): _____ Phone Number:_____

Address (if available): _____

_____ _____

PATIENT SIGNATURE DATE