Okatie Surgical Partners

GENERAL MEDICAL HISTORY

Name: _____ **DOB:** _____

Reason for Visit Today: _____

DO YOU HAVE ANY ALLERGIES? _____

Social History:

	Yes	No
Tobacco		
Alcohol		
Substances		

If you answered "yes" to any of the above, please give more details:

Medications:

Name	Dose	Frequency

Health History:

	Yes	No
Anemia		
Arthiritis		
Asthma		
Bleeding Disorder		
Cancer		
Depression		
Diabetes		
GI Problems		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Low Blood Pressure		
Mental Illness		
Seizures		
Stroke		
Tuberculosis		
Thyroid Disease		

Preventative Care:

	Date
Bone Density	
Colonoscopy	
EKG	
Mammogram	
PSA	

Family History:

Disease	Relation

Additional Medical Information, including Surgeries: _____

_____

Signature: _____ **Date:** _____

Primary Care Physician: _____

OKATIE SURGICAL PARTNERS

Please check only those symptoms you are presently experiencing as they relate to your visit today.

_____chills

_____fever

_____weight gain/loss

_____abdominal pain

_____bloating

_____blood in stool

_____rectal bleeding

_____change in bowel habits
_____diarrhea
_____constipation

_____decreased appetite

_____difficulty swallowing

_____vomiting blood

_____nausea/vomiting

_____reflux

_____skin lesions

_____blood in urine

_____frequent urination

_____difficulty urinating

_____back pain

_____bone/joint pain

_____myalgia

_____difficulty breathing

_____bloody sputum

_____easy bruising

_____easy bleeding

_____chest pain

_____difficulty breathing on exertion

_____irregular heart beat/ palpitations

_____frequent thirst

_____focal weakness

_____loss of consciousness

_____seizures

Name_____ Date_____

Signature_____