WELLSTAR SURGICAL ASSOCIATES OF MARIETTA, LLC

NAME: ________________________________ **Referring Doctor:**___________________________________
AGE: ______
DOB: ________________________________ **PCP:** ____

MEDICAL HISTORY: *The purpose for the following questions is to obtain a complete medical history. This information will remain confidential and part of your medical record.*

ILLNESS:

☐ Anemia	☐ Blood Transfusion	☐ COPD/Asthma
☐ Bleeding Disorder	☐ Diabetes	☐ Stroke/TIA
☐ High Blood Pressure	☐ Hernia	☐ Seizures
☐ Heart Attack	☐ Heart Failure	☐ Other: _______________
☐ Jaundice	☐ Hepatitis	_______________
☐ Blood Clot	☐ Cancer type: ___________________	_______________

SURGERIES / DATE:

☐ Appendectomy __________	☐ Gallbladder ___________	☐ Hemorrhoids ___________	☐ Breast ___________________
☐ Thyroid _________________	☐ Kidney _______________	☐ Tonsils ________________	☐ Hysterectomy _____________
☐ Colonoscopy Date: ________________________________		☐ Cardiac Date: __________	☐ Other: ___________________

MEDICATIONS DOSE FREQUENCY	MEDICATION DOSE FREQUENCY
1. ______________________________________	5. ______________________________________
2. ______________________________________	6. ______________________________________
3. ______________________________________	7. ______________________________________
4. ______________________________________	8. ______________________________________

MEDICATION ALLERGIES:	REACTION:
1.	1.
2.	2.
3.	3.

SOCIAL HISTORY:

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Children: ____
Occupation ____

Tobacco:	☐ No Quit when? _________	☐ Yes How much? _____________
Alcohol Consumption	☐ No Quit when? _________	☐ Yes How much? _____________
Drugs:	☐ No Quit when? _________	☐ Yes How much? _____________

FAMILY HISTORY:	Age:	Health Issues
Mother		
Father		
Brothers		
Sisters		
Grandparents		

REVIEW OF SYSTEMS

General	☐ Fever ☐ Night Sweats ☐ Weight Loss ☐ Weight gain ☐ Loss of appetite
Skin	☐ Rash ☐ Sores ☐ Moles that have changed color or size
Lymph Glands	☐ Swelling in neck ☐ Swelling in the armpit ☐ Swelling in the groin
Lungs	☐ Cough ☐ Cough blood ☐ Shortness of breath ☐ COPD ☐ Chronic bronchitis
Heart	☐ Chest pain ☐ Angina ☐ Heart murmur ☐ Rheumatic fever
Abdominal Organs	☐ Abdominal pain ☐ Heartburn/indigestion ☐ Ulcers ☐ Vomiting blood ☐ Liver disease ☐ Hepatitis ☐ Gallstones ☐ Heavy drinking ☐ Diarrhea ☐ Constipation ☐ Blood in stools ☐ Tarry stools ☐ Hemorrhoids
Kidney/Bladder disease	☐ Difficult/painful urination ☐ Blood in urine ☐ Kidney stone
Women Only – Genitals	☐ Date of last period _________ ☐ Vaginal discharge ☐ History of STD (Sexually Transmitted Disease)
Men Only – Genitals	☐ History of STD (Sexually Transmitted Disease) ☐ History of trauma
Nervous System	☐ Stroke/TIA ☐ Seizures/fits/convulsions ☐ Numbness/tingling
Psychiatry	☐ Anxiety ☐ Depression ☐ Suicidal thoughts

Patient Signature: ________________________________ **Date**: ______________________________

Physician Signature: ________________________________ **Date:** ______________________________