WELLSTAR Medical Group
Summit Surgical

NAME: _____ DOB: __/__/____ HT: _____ WT: _____

What is your current smoking status: (Circle one)
NEVER FORMER CURRENT OCCASIONAL

Do you use smokeless tobacco? YES NO

If yes, how much and how often: _____

DO YOU HAVE ALLERGIES? If yes, please list:
_____

_____

PREFERRED PHARMACY: _____ Telephone# _____

DO YOU TAKE ANY OF THE FOLLOWING? (Please circle)
Aspirin/BC Powder Yes / No Ibuprofen/Motrin/Advil Yes / No Effient Yes / No
Coumadin Yes / No Plavix Yes / No Xarelto Yes / No
Pradaxa Yes / No

LIST ALL OTHER CURRENT MEDICATIONS: (Attach additional sheet if necessary)

Name	Dose	Name	Dose

MEDICAL HISTORY (Please circle those that apply, and list any others not listed)

Anemia	**Depression**	**Heart Murmur**	**Seizures**
Anxiety	**Diabetes**	**High Cholesterol**	**Sleep Apnea**
Arthritis	**Emphysema**	**Hypertension**	**Ulcers**
Asthma	**GERD/Reflux**	**Hyperthyroidism**	**Other:**
Cancer	**Headaches**	**Hypothyroidism**	**_____**
Coronary Artery Disease		**Kidney Disorder**	**_____**
COPD	**Heart Failure**		

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NAME: _____ **DOB:** __/__/____

SURGICAL HISTORY: (Please list)

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS: Please circle all that you have had in the past 6 months:

Constitution
Activity Change
Appetite Change
Chills
Excessive Sweating
Fatigue
Fever
Unexpected Weight Change

HENT
Neck Pain
Neck Stiffness
Congestion
Sore Throat
Trouble Swallowing

GU
Difficulty Urinating
Flank Pain
Frequency
Hematuria

RESPIRATORY
Chest Tightness
Cough
Shortness of Breath
Wheezing

CARDIO
Chest Pain
Leg Swelling
Palpitations

GI
Abdominal Distension
Abdominal Pain
Anal Bleeding
Blood in Stool
Constipation
Diarrhea
Nausea
Rectal Pain
Vomiting

ENDOCRINE
Cold Intolerance
Heat Intolerance
Excessive Thirst
Excessive Urination

MUSCULAR
Back Pain
Difficulty Walking
Joint Swelling
Muscle Pain
Muscle Weakness

SKIN
Color Change
Rash
Wound

NEUROLOGICAL
Dizziness
Headaches
Seizures
Weakness

HEMATOLOGIC
Enlarged Lymph Nodes
Bruise / Bleeds Easily

PSYCHIATRIC
Behavioral Problems
Depressed
Hallucinations
Nervous / Anxious

ALLERGIES
Food Allergies
Environmental Allergy

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NAME: _____ DOB: __/__/____

FAMILY HISTORY

	Mother	Father	Brother	Sister	*MGM	*MGF	*PGM	*PGF
Heart Disease								
Hypertension								
Diabetes								
Asthma								
Cancer (Specify Type)								
Kidney Disease								
Thyroid Disease								
Seizures								
Bleeding Disorder								
Autoimmune								

***Maternal Grandmother, Grandfather, and/or Paternal Grandmother, Grandfather**

Please list any additional significant family history not included above:

_____

_____

_____

_____

_____

_____