FLORIDA LAKES SURGICAL

Name: ______________________________ Date: _______ Male: ___ Female: ____

DOB: ________________ SSN#: ______________________ Home Phone: _____________________

Mailing Address: ______________________________________ Work Phone: _____________________

City:___________________________State:__________Zip:_________Guarantor:_____________________

Insurance: ________________________ Policy #: ___________________

Insurance: ________________________ Policy #: ____________________

Primary Care Physician: _________________________ Referring Physician: _________________________

Diagnosis/Problem: ____

History of Present Illness (Describe in detail what is bothering you, when it started, treatments and tests that have been performed.)

Medical History (list all illnesses you have been treated for i.e. diabetes, hypertension, stroke, diverticulosis)

Surgical History and dates (List all operations/injuries, i.e. colonscopy, appendix, gallbladder, aneurysm, total knee)

Allergies and Adverse Reactions (i.e. penicillin, sulfa, latex, iv dye, betadine, pain meds)

Social (i.e. married, working/retired, smoking, alcohol consumption, drugs, have you ever, when did you quit, how much currently)

Family History (any relative with medical disease, i.e. heart disease, stroke, diabetes, cancer. If cancer, what type, how old, living or deceased)

Medication (list meds, dose, and what they are for, i.e. Coumadin for blot clots or Atenolol for high blood pressure)

3750 Emergency Lane, Suite 3 ● Sebring, FL 33870
Office: 863-402-5600 Fax: 863-402-5602

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PLEASE CIRCLE ANY SYMPTOMS/PROBLEMS YOU HAVE AN AND EXPLAIN BELOW.

GENERAL: Recent change in appetite, weight gain, or weight loss. Fevers, chills, or sweats.
HEAD: Occasional mild headaches, Migraines, Recent trauma or concussion
EYES: Recent visual changes or double vision, Presbyopia (need bifocals), Cataracts, Glaucoma
EARS: Ringing, infection, drainage, or pain. Mild hearing loss, Hearing impaired, use hearing aid
NOSE/THROAT: Frequent nose bleeds, bleeding gums, sores in mouth or lips, difficulty swallowing, or hoarseness. Chronic sinus congestion, allergies, or hay fever, Loose/broken teeth, dentures, Loud snoring
LUNGS: Wheezing, chronic cough, emphysema or COPD, coughing up blood. TB or positive skin test, Sleep apnea or use CPAP, Pulmonary embolus, Asthma
HEART: Chest pain or angina, heart skips, rapid heart rate, exertional or nocturnal shortness of breath. Cardiac testing within the last year (EKG, stress test, cardiac catheterization, or echo), Heart attack, Atrial fibrillation, Pacemaker, Mitral valve prolapse, Hypertension.
BREAST: Current breast mass, nipple discharge, personal history of breast cancer, Breast augmentation, Current abnormal mammogram or sonogram, Last mammogram________(month and year), Over due for mammogram. Every had a breast biopsy?
DIGESTIVE: Abdominal pain, nausea, vomiting, bloating, heartburn or GERD, diarrhea, constipation, Cirrhosis, Jaundice, Gallstones, Black stools, blood in stool, hemorrhoid problems, History of cancer, Crohn's disease, ulcerative colitis, diverticulosis, or irritable bowel disease.
GENITO-URINARY: MEN: Difficulty urinating, difficulty holding urine, frequent urination at night mild or severe. Prostate cancer, Blood in urine, kidney stones, Herpes, Discharge from penis
WOMEN: Difficulty urinating, difficulty holding urine, frequent urination at night, Menopause at age___ , Onset of period___, Hysterectomy at age___, Were ovaries removed? __________, Blood in urine, kidney stones, Genital Herpes, Last menstrual period_____. First pregnancy ___. Number of pregnancy ___. Number of kids ___.
MUSCULOSKELETAL: Pain in joints, pain in muscles, muscle weakness, fibromyalgia, arthritis under treatment Chronic back problems, Swollen ankles, varicose veins
NEUROLOGICAL: Dizziness, loss of consciousness, transient loss of function, stroke, seizures
SKIN: Rash, psoriasis, non healing lesions, history of skin cancers or melanoma
PSYCHIATRIC: Anxiety, depression, psychiatric therapy. Current treatment for depression or anxiety
ENDOCRINE: Thyroid disorder, masses, heat or cold intolerance, or taking thyroid medication Diabetes under treatment, excessive thirst, hunger, or urination. Adrenal or pituitary disorder. Pancreatitis
HEMATOLOGIC: Anemia, bruise easily, excessive bleeding, swollen glands, leukemia, lymphoma, transfusions Blood clots, phlebitis, deep venous thrombosis, anticoagulated with coumadin, sickle cell
INFECTIONS: HIV Positive, history of hepatitis (type ________), staph infections, MRSA or ORSA
ANYTHING ELSE: ____

I have fully completed the above form and verify its accuracy.

Patient's Signature:____ Date: ______________________
Reviewed by: ______________________________

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