

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. colonoscopy, 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)

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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: _____

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Bariatric:

Heaviest Weight: _____ # When: _____ Lowest Weight (since 21): _____ # When: _____

Childhood Weight: Underweight Overweight Average

Reasons for Obesity: _____

History of Eating Disorders (Anorexia/Bulemia/BingeEating): _____

How Obesity Impacts You Life/Comfort: _____

Current Pant Size: _____ Goal Pant Size: _____ Current Shoe Size: _____

Weight Loss Program:

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Weight watchers | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Nurtisystem | <input type="checkbox"/> Atkins |
| <input type="checkbox"/> South Beach | <input type="checkbox"/> Optifast | <input type="checkbox"/> Prescription meds | <input type="checkbox"/> Exercise programs |
| <input type="checkbox"/> Slimfast | <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Fasting | <input type="checkbox"/> Other _____ |

Medical Conditions/Co-morbidities:

- | | | | |
|--|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Gerd | <input type="checkbox"/> Joint pain |

Family History of obesity or any of above chronic diseases? _____

Exercise:

Type: _____ Duration: _____

Frequency: _____