PARAGON SURGICAL SPECIALISTS **DATE**________________________

Name ____ Birth Date__________________

Male______ Female______ Primary Care Physician__________________________________

Referring Doctor (if different from Primary) ___________________________________

HISTORY OF PRESENT ILLNESS

Today's Complaint ____

ALLERGIES:

Medications____

Contactants:	Adhesive Tape	Yes	No
	Betadine	Yes	No
	Latex	Yes	No
Foods:	Shellfish	Yes	No

FAMILY HISTORY:

Blood Vessel Disease	Yes	No
Cancer:		
Breast	Yes	No
Colon	Yes	No
Lung	Yes	No
Melanoma	Yes	No
Skin	Yes	No
Thyroid	Yes	No
COPD	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Kidney Failure	Yes	No
Seizure Disorder	Yes	No
Stroke	Yes	No

PAST MEDICAL HISTORY:

Arthritis	Yes	No
Asthma	Yes	No
Bleeding Tendency	Yes	No
	If yes what type?__________	
Blood Clots	If yes, Legs Yes No	
	Lung Yes No	
Cancer	Yes	No
	If yes what type?______________	
COPD	Yes	No
Diabetes	Yes	No
Heart Attack	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
HIV/AIDS	Yes	No
Kidney Failure	Yes	No
	If yes on Dialysis? Yes No	
Malignant Hyperthermia	Yes	No
Seizure Disorder	Yes	No
Stroke	Yes	No

SOCIAL HISTORY:

Drug Use	Yes	No
Alcohol Use	Yes	No
Smoking	Yes	No

PAST SURGICAL HISTORY:

Abdominal		
Appendectomy	Yes	No
Bowel Resection	Yes	No
Gallbladder Removal	Yes	No
Liver Resection	Yes	No
Pancreatic Resection	Yes	No
ENT		
Sinus Surgery	Yes	No
Tonsillectomy	Yes	No
Tracheostomy	Yes	No
GYN		
Abdominal Hysterectomy	Yes	No
Removal of Tubes and Ovaries	Yes	No
Vaginal Hysterectomy	Yes	No
Heart		
Bypass Grafts	Yes	No
Pace Maker	Yes	No
Stent Placement	Yes	No
Valve Replacement	Yes	No
Hernia		
Groin	Yes	No
Hiatal	Yes	No
Incision	Yes	No
Naval	Yes	No
OB		
C-section	Yes	No
Tubal Ligation	Yes	No
Orthopedic		
Any Metal Rods in Legs	Yes	No
Total Hip	Yes	No
Total Knee	Yes	No
Total Shoulder	Yes	No
Thoracic		
Esophageal Resection	Yes	No
Lung Resection	Yes	No
Vascular		
Aneurysm		
Abdominal Aorta	Yes	No
Intracranial	Yes	No
Thoracic Aorta	Yes	No
Leg Bypass	Yes	No
Carotid Artery Surgery	Yes	No

MEDICATIONS:

Please List: ____

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ARE YOU PREGNANT? Yes No

REVIEW OF SYSTEMS:

General
- Fatigue Yes No
- Fever Yes No
- Weight Gain > 10 lbs Yes No
- Weight Loss < 10 lbs Yes No

Skin
- Hair Loss Yes No
- Nail Changes Yes No
- Pruritus Yes No
- Rash Yes No
- Skin Color Changes Yes No

HEENT
- Blurred Vision Yes No
- Head Injury Yes No
- Visual Loss Yes No
- Hearing Loss Yes No
- Hoarseness Yes No
- Sore Throat Yes No

Neck
- Neck Mass Yes No
- Swollen Glands Yes No

Respiratory
- Chronic Cough Yes No
- Difficulty Breathing Yes No
- Wheezing Yes No

Breast
- Breast Mass Yes No
- Breast Pain Yes No
- Breast Swelling Yes No
- Nipple Discharge Yes No
- Skin Changes On the Breast Yes No

Cardiovascular
- Chest Pain Yes No
- Palpitation Yes No
- Swelling of Extremities Yes No

Gastrointestinal
- Abdominal Pain Yes No
- Bloody Stool Yes No
- Constipation Yes No
- Diarrhea Yes No
- Difficulty Swallowing Yes No
- Heartburn Yes No
- Indigestion Yes No
- Nausea Yes No
- Vomiting Yes No

Genitourinary:

Male:
- Blood in urine Yes No
- Change in urinary stream Yes No
- Incontinence Yes No
- Painful Urination Yes No
- Testicular mass Yes No
- Testicular pain Yes No

Female:
- Blood in Urine Yes No
- Discharge Yes No
- Incontinence Yes No
- Painful Urination Yes No
- Vaginal Bleeding Yes No

Musculoskeletal:
- Back Pain Yes No
- Joint Pain Yes No
- Joint Stiffness Yes No
- Joint Swelling Yes No
- Muscle Weakness Yes No

Neurological:
- Headache Yes No
- Seizures Yes No
- Stroke Yes No
- Weakness in extremities Yes No

Psychiatric:
- Anxiety Yes No
- Depression Yes No
- Panic Attacks Yes No

Endocrine:
- Excessive Thirst Yes No
- Thyroid Problems Yes No

Hematology:
- Blood Clots Yes No
- Easy Bruising Yes No
- Enlarged Lymph Nodes Yes No
- Prolonged Bleeding Yes No