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JANDALI SURGICAL ASSOCIATES

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MEDICAL HISTORY

Name:_____ Date of Birth:_____Age:_____
Reason for Visit:_____ Height:____ft____in

Medical History

Do you take Aspirin or other blood thinners □ Yes □ No	Do you take immune system modifying medications □ Yes □ No

List Medications with dosages: (□ Check here if providing a separate list of medications with the dosages)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: _____ LATEX Allergy □ Yes □ No

Pharmacy Used (Name, location, phone number): _____

Medical Illnesses

List any not mentioned:

High blood pressure	□ Yes	□ No	_____	_____
Heart disease/Heart attack	□ Yes	□ No	_____	_____
Diabetes	□ Yes	□ No	_____	_____
Asthma	□ Yes	□ No	_____	_____

Surgical History

List your surgeries	Surgeon	Approx Date

Other History

Tobacco □ No □ Yes □ Quit →→→→→→ **please fill tobacco questionnaire at the end**
Alcohol □ No □ Quit How long ago? _____ □ Yes. How much? _____
Work □ No □ Disabled □ Retired □ Yes. Occupation: _____ / Heavy lifting □ Yes □No
Have you ever had a colonoscopy? ☐ No ☐ Yes: Year _____
Have you ever had a mammogram? ☐ No ☐ Yes: Year _____

Family History

Heart disease/Heart Attack: □ No □ Yes, relationship:_____
Diabetes: □ No □ Yes, relationship:_____
Cancer: □ No □ Yes, relationship:_____
Other: _____

TOBACCO QUESTIONNAIRE

NONSMOKER	CURRENT SMOKER	FORMER SMOKER
○ I do not smoke, use tobacco or other nicotine products ○ I do not smoke, but I do use other tobacco or nicotine products. (please explain below) _____ _____ _____ _____	How often do you smoke ○ Every day ○ Some days, but not every day How many cigarettes per day ○ 5 or less ○ 6-10 ○ 11-20 ○ 21-30 ○ 31 or more How soon after waking up do you smoke ○ Within 5 minutes ○ 6-30 minutes ○ 31-60 minutes ○ After 60 minutes **Are you interested in quitting** ○ **Ready to quit** ○ **Thinking about quitting** ○ **Not ready to quit**	How long since you last smoked: ○ <1 month ○ 1-3 months ○ 3-6 months ○ 6-12 months ○ 1-5 years ○ 5-10 years ○ >10 years

Name:_____

REVIEW OF SYSTEMS

(non-selection will be taken to mean absence of the symptom)

General	**NONE APPLY**
□fatigue □fever □night sweats □weight gain more than 10 lbs □weight loss more than 10 lbs	□
Skin	
□change in wart/mole □itching □new lesions □rash	□
HEENT	
□headache □visual disturbance □hearing loss □frequent colds □bleeding gums □hoarseness	□
Neck	
□swollen glands	□
Respiratory	
□cough □difficulty breathing □snoring □sleep apnea	□
Breast	
□breast mass □breast pain □nipple discharge □breast cancer	□
Cardiovascular	
□chest pain □elevated blood pressure □shortness of breath □swelling of extremities □leg pain/swelling	□
Gastrointestinal	
□abdominal pain □constipation □diarrhea □difficulty swallowing □bloating □nausea □vomiting □heartburn □rectal bleeding	□
Female GU (females only)	
□absence of menstruation □incontinence □irregular menstruation □painful urination □ pelvic pain □urgency □vaginal bleeding □vaginal discharge	□
Male GU (males only)	
□frequency □incontinence □urination at night □testicular mass □testicular pain	□
Musculoskeletal	
□calf pain □joint pain □muscle cramps	□
Neurological	
□dizziness □weakness	□
Psychiatric	
□anxiety □depression	□
Endocrine	
□cold intolerance □excessive thirst □excessive urination □thyroid problems	□
Hematology	
□anemia □enlarged lymph nodes □prolonged bleeding	□

The above has been filled to the best of my knowledge	Patient/caregiver signature & date→
The above has been reviewed and confirmed with the patient	Physician signature & date→