Grand Strand Surgical Specialists

Name: _____
Date of Birth: _____
Age: _____
Sex: _____
Referring Physician: _____
Preferred Pharmacy: _____
Primary Care Physician: _____

Why are you here to see the Doctor today? _____

Currently Prescribed Medications:

Name of Medication	Directions for Use	Prescribing Physician	Medication Problem (Why the medication was prescribed) Ex: hypertension, thyroid disease, heart disease, etc

My Medical History:

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Allergies/Intolerances:

Allergy		What type of reaction
Latex	Yes/No	
Betadine	Yes/No	
Tape	Yes/No	
Penicillin	Yes/No	
Other (please list)		
1.		
2.		
3.		

GYN/OB History (Women Only):

1) Age at the time of first menstrual cycle _____
2) Number of Children: #_____ N/A_____
3) Your age at the time of first child _____ Natural Birth____ C-Section_____
4) Are you currently taking any form of Hormonal placement therapy to Include: (Birth Control, Hormones, other) if yes, please describe_____
5) Date of Last Menstrual Period: _____
6) Last Mammogram: _____

Male Genitourinary (Men Only):

1) Have you ever had prostate problems? Yes / No
2) Testicular Tumor? Yes / No
3) Inability to pass urine following a medical procedure? Yes / No

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Surgical History:

Operations		Date	Surgeon/Hospital
Tonsils	Yes / No		
Removal of appendix	Yes / No		
Hernia repair	Yes / No		
Gallbladder removed	Yes / No		
Hysterectomy	Yes / No		
Heart surgery or stents	Yes / No		
Orthopedic surgery	Yes / No		
Colon resection	Yes / No		
Thyroid surgery	Yes / No		
Breast surgery	Yes / No		
Other (please list)			
1.			
2.			
3.			

Family History:

Medical History		Family Member	Comments
Cancer & Type	Yes / No		
Diabetes	Yes / No		
High Blood Pressure	Yes / No		
Heart Disease	Yes / No		
Thyroid Disease	Yes / No		
Kidney Disease	Yes / No		
Stroke	Yes / No		
Tuberculosis	Yes / No		
Hereditary Illness	Yes / No		
Other (please list)			
1.			
2.			
3.			

Social History:

Do you drink alcohol?	Yes / No
If yes, how many drinks per occasion?	
If yes, how many drinks per week?	
Do you smoke, dip or chew?	Yes / No
If yes, what type of tobacco?	Smoking / Smokeless
If yes, please circle the type of smoking/smokeless: Chewing tobacco / dissolvable powdered tobacco / snuff / snus / cigarettes / pipes / cigars / hookah pipe / electronic cigarettes	
If yes, how often?	
If not, have you ever smoked? If yes, how long ago?	
Do you currently use drugs that are not prescribed by	Yes / No

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a physician?	

Please circle any conditions which apply to you:

Constitutional	Fever	Weight Loss	Night Sweats	Fatigue	Nausea
Eyes	Glaucoma	Glasses	Contacts	Blurred Vision	Double Vision
	Cataracts	Blindness	Previous Eye Trauma		
Ears, Nose & Throat	Hearing Aids	Bleeding	Hearing Loss	Dentures	Sores
	Pain	Sore Throat	Difficulty swallowing		Nasal polyps
	Snoring/Sleep Apnea		Nasal fracture		
Cardiovascular	Chest Pain	Difficulty breathing or shortness of breath with exertion			
	Aneurysm	Ankle Swelling	Angina	Heart Failure	Heart Attack
	Murmur	Leg pain w/ walking		Leg pain w/ rest	
	Hypertension	Irregular Pulse	Previous Stent or Bypass		
Respiratory	COPD	Asthma	Bronchitis	Pneumonia	Emphysema
	Lung Cancer	Previous Lung Surgery		Oxygen at home	
Gastrointestinal	Nausea	Vomiting	Vomiting blood	Black bowel movement	
	Red Blood Per Rectum		Constipation	Diarrhea	Pancreatitis
	Inflammatory Bowel Disease		Functional Bowel Disease		Surgery
Musculoskeletal	Weakness		Wheelchair	Walker	Cane
	Arthritis		Fibromyalgia	Hernia	Gout
	Joint Replacement		Fracture		
Genitourinary	Urination problems: Frequency, Difficulty, Burning, Bloody				
	Prostate or Testicular Problems			Ovary or Uterine Problems	

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Skin	Eczema		Psoiasis	Hair loss	Rashes
	Nonhealing Wound		Infection	Cancer	Mass
Breast	Mass	Pain	Nipple Discharge		Infection
	Skin Changes		Shape changes		
Neurological	Tremor	Seizures	Mini-stroke/TIA		
	Stroke	Back pain	Dementia	Neuropathy	Alzheimer's
	Memory Loss				
Psychiatric	Mental Illness		Depression		Insomnia
	Addiction	Alcoholism			
Endocrine	Diabetes	Thyroid	Parathyroid	Pancreas	Adrenal
Hematological/Lymph	Coumadin	Bleeding problems		Previous DVT	
	Anemia	Enlarged lymph nodes		Previous PE	
	Lymphoma	Leukemia			
Immune System	HIV/AIDS	Immune Deficiency		Autoimmune Disease	
	Previous Transplant		Steroid Use		

_____ _____

Patient Signature **Date** **Physician Signature** **Date**