Surgical Associates of Marquette, PC

1414 West Fair Avenue, Suite 230
Marquette, MI 49855
Phone: (906) 225-3853 Fax: (906) 228-4065

Name: _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____

Primary Doctor: _____ **Cardiologist:** _____

Local Pharmacy: _____
(Name/City/Phone #)

Mail Order Pharmacy: _____
(Name/City/Phone #)

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Timing/Onset: When did symptoms first occur? _____

Duration: Frequency of symptoms? _____

Characterized as/Severity: Describe the severity of the symptoms/pain. _____

Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _____

_____

Modifying Factors: What makes the condition better and/or worse? _____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you had any of the following (currently or in the past)?

___ Alcohol abuse
___ Angina (chest pain)
___ Arthritis
___ Asthma
___ Bladder problem
___ Bleeding disorder
___ Cancer: _____
___ Cardiac defibrillator
___ Chronic pain
___ Colitis
___ Diabetes
___ Dialysis patient
___ Diverticulitis
___ Drug abuse
___ Emphysema/COPD
___ Epilepsy
___ Head injury
___ Heart attack
___ Heart failure (fluid in lungs)
___ Heart valve disorder
___ Heartburn/Reflux
___ Hepatitis
___ Hypertension
___ IBS
___ Jaundice
___ Kidney disorder
___ Migraine headaches
___ Multiple sclerosis
___
___ Pacemaker
___ PCOS
___ Pneumonia (last 2 mo)
___ Psychiatric disorder
___ Recent infection
___ Seizures
___ Shortness of breath
___ Sleep apnea
___ Stomach ulcers
___ Stroke
___ Other: _____

ALLERGY HISTORY:

☐ **NKDA (No Known Drug Allergies)**

Latex No[ ] Yes [ ] Iodinated Contrast Dye No[ ] Yes[ ] IVP Dye No[ ] Yes[ ]

Medication Allergies:

_____

_____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	**Dosage**	**How Often**

PAST SURGICAL HISTORY:

Please list any surgery/procedure you have had in the past. Then write the year of the surgery/procedure on the line to the right of it. ☐ **None**

Past Surgeries: _____

_____

_____

_____

Have you had a joint replacement surgery? ☐ Yes ☐ No

Problems with pain control after surgery? ☐ Yes ☐ No

Problems with anesthesia? ☐ Yes ☐ No

Unexplained fever after surgery? ☐ Yes ☐ No

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition and indicate if the family member passed away due to that condition.

	Mother	**Father**	**Sibling**	**Child**	**Mother's Parents**	**Father's Parents**
Stroke						
Seizure						
Heart Problems						
High Blood Pressure						
Cancer						
Anesthetic Problems						

SOCIAL HISTORY:

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Current every day smoker
☐ Current some day smoker ☐ Former smoker ☐Never smoker ☐ Unknown if ever smoked

Exposer to or ever have TB/HIV/AIDS/MRSA/VRE? ☐ Yes ☐ No
Psychiatric disorder/Emotional problems? ☐ Yes ☐ No
Drug/Alcohol problems or treatment? ☐ Yes ☐ No
Religious restrictions to medical care? ☐ Yes ☐ No

PREGNANCY / MENSTRUAL HISTORY: (New female patients only)

Pregnancy Status: ☐ Not pregnant ☐ Pregnancy status unknown ☐ Pregnant ☐ Positive home pregnancy test

Last Menstrual Period:

Date: _____ Hysterectomy: _____

Post menopausal: _____