TALLGRASS SURGICAL SPECIALISTS, PA/GENERAL, VASCULAR & THORACIC SURGICAL GROUP

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PATIENT HISTORY FORM **DATE FORM COMPLETED**_____

Name:_____ M/F Date of birth ____/____/____Age _____
First MI Last

Address:_____City_____State_____Zip Code_____

Phone # (Home)_____(Work)_____(Cell)_____

SSN_____Patient email address_____

Responsible Party_____

Referred by/Physician_____Friend_____Self_____Family Physician_____

Emergency Contact_____Phone_____

Reason for visit_____

Previous surgeries or hospitalizations:

Operation	Year	Operation	Year

Patient Past Medical History:

Yes	No	High blood pressure	Yes	No	Asthma
Yes	No	Congestive heart failure	Yes	No	Emphysema/chronic bronchitis
Yes	No	Heart attack	Yes	No	Thyroid Disorder
Yes	No	Cancer type_____	Yes	No	Radiation therapy
Yes	No	Depression	Yes	No	Kidney failure
Yes	No	Bleeding disorder	Yes	No	Diabetes (Year of diagnosis?_____)
Yes	No	Hepatitis/liver disease			Insulin? Yes/No
Yes	No	Sleep apnea? (CPAP? Yes/No)			

Other Medical Concerns_____

For Women Only: Last menstrual cycle_____Are you pregnant? Yes No

Number of pregnancies_____Number of live births_____Number of living children_____

Are you currently on birth control? Yes (what kind?)_____ No____

Family Medical History (Please list who and if positive for cancer, what kind)

Cancer_____

Heart disease_____

Diabetes_____

Other_____

Social History: (Please circle) Alcohol use Yes No Illicit drugs/marijuana Yes No

Tobacco Yes No packs per day_____years_____

Employer/Occupation_____**Marital status:** S M D W

Yes	No	Have you taken any diet pills in the past two weeks?
Yes	No	Have you taken or are you currently taking Aspirin or an Aspirin product in the past two weeks?
Yes	No	Have you taken or are you currently taking steroids (Prednisone) in the past six months?
Yes	No	Are you taking any blood thinners (Coumadin or Warfarin)?
Yes	No	Are you taking any diuretics or water pills?

Do you have any drug allergies or reactions to medications? Please list drug and reaction (hives, etc.):

_____

Current Medications (including herbal and over-the-counter):

Name	Dose	Frequency	Name	Dose	Frequency