Pendurthi Surgical Associates, LLC

Date _____

Name _____ Age_____ DOB_____ Sex: ❑ M ❑ F SS# _____

Address _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email Address _____

Occupation _____ Employer _____

Language _____ Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic ❑ Refused Race _____

Marital Status: ❑ Single ❑ Married ❑ Significant Other ❑ Separated ❑ Divorced ❑ Widowed

EMERGENCY CONTACT/RELATION (Someone not living at the same address if possible)

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Spouse's Name _____ DOB_____ Spouse's Employer _____

Employer's Address _____ Spouse's Work Phone _____

PRIMARY CARE PHYSICIAN

Name_____

Address _____

_____

Phone _____

❑ Forward a copy of my reports to this doctor.

REFERRING PHYSICIAN

Name_____

Address _____

_____

Phone _____

❑ Forward a copy of my reports to this doctor.

OTHER PHYSICIAN

Name_____

Address _____

_____

Phone _____

❑ Forward a copy of my reports to this doctor.

OB/GYN

Name_____

Address _____

_____

Phone _____

❑ Forward a copy of my reports to this doctor.

OTHER PHYSICIAN

Name_____

Address _____

_____

Phone _____

❑ Forward a copy of my reports to this doctor.

OTHER PHYSICIAN

Name_____

Address _____

_____

Phone _____

❑ Forward a copy of my reports to this doctor.

Reason for Visit _____

Do you have an AICD (pacemaker)? ❑ No ❑ Yes **Do you take blood thinners?** ❑ No ❑ Yes

MEDICATIONS/DOSAGES

Please list medications and supplements you take. **Instead of writing your medications here, you may bring a list of them with you to your appointment.**

Medication	Dose	Medication	Dose	Medication	Dose

PHARMACY _____ Address _____ Phone_____

ALLERGIES

Please list any medications, foods, or other substance to which you have had an allergic reaction to.

Medication/Other	Reaction

OVER ⇨

MEDICAL HISTORY

Please list any hospitalizations other than surgery; add any details that might be helpful.

SURGICAL HISTORY

Please list any surgeries you have had.

Surgery	Reason	Hospital/State	Year

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood? _____

Mammogram? _____ Colonoscopy? _____ Prostate exam? _____

Past Medical History and Review of Systems:

Please check if you have had any problems with or are presently complaining of any of the following. Also indicate length of time experiencing problem:

- ☐ High blood pressure _____
- ☐ High cholesterol _____
- ☐ Diabetes _____
- ☐ Cancer: Type _____
- ☐ Heart Disease _____
- ☐ Chest pain/Chest tightness _____
- ☐ Shortness of breath _____
- ☐ GERD _____
- ☐ Palpitations _____
- ☐ Frequent urination _____
- ☐ Diverticulitis _____
- ☐ Asthma _____
- ☐ Colon Polyps _____
- ☐ Breast Problems _____
- ☐ TB _____
- ☐ Skin Cancers _____
- ☐ Indigestion _____
- ☐ Constipation _____
- ☐ Diarrhea _____
- ☐ Stomach Ulcer _____
- ☐ Hemorrhoids _____
- ☐ Colitis _____
- ☐ Hepatitis or jaundice _____
- ☐ Hypothyroidism _____
- ☐ Headache _____
- ☐ Kidney disease _____
- ☐ Kidney stones _____
- ☐ Difficulty urinating _____
- ☐ Arthritis _____
- ☐ Low back problems _____
- ☐ Skin diseases _____
- ☐ Blood disorders _____
- ☐ Venereal disease _____
- ☐ Anxiety _____
- ☐ Depression _____
- ☐ Anemia _____
- ☐ Alcohol abuse _____
- ☐ Gout _____
- ☐ Hyperthyroidism _____
- ☐ Thyroid nodule _____
- ☐ Other _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY

List any relatives who have or previously had cancer, indicate the location of cancer or tumor, and how the individual was related to you.

Relative	Location of cancer/tumor	Age of diagnosis	Status
			☐ Living ☐ Deceased
			☐ Living ☐ Deceased
			☐ Living ☐ Deceased
			☐ Living ☐ Deceased
			☐ Living ☐ Deceased
			☐ Living ☐ Deceased

Social History:

How many children do you have? _____ Are you currently employed outside the home? ☐ No ☐ Yes Are you retired? ☐ No ☐ Yes

Have you ever smoked? ☐ No ☐ Yes If yes, how many packs per day? _____

Previous smoking history ☐ No ☐ Yes How many years? _____ year quit _____

Do you drink alcoholic beverages? ☐ No ☐ Yes Amount per day/week? _____

If you previously drank heavily, how much, when did you quit? _____

Do you use illegal substances or drugs? ☐ No ☐ Yes If yes, which one(s)? _____

Do you have a "living will"? ☐ No ☐ Yes Advanced Directive? ☐ No ☐ Yes Do you have an organ donor card? ☐ No ☐ Yes

SIGNATURE _____ Date _____