Surgical Associates of Utica
Pre-Examination Information

Patient Name_____ Date of Birth_____

Reason you are seeing a Surgeon today:_____

Referring Physician_____ Family Physician_____

Do you live alone?_____Who lives with you?_____
Do you have? Health Care Proxy □ Living Will □ Do Not Resuscitate Order □ *(Please bring a copy for our files)*

Check areas below that relate to your current health status: If yes, **circle** symptoms that apply**.**

Review of Systems	Yes	No	Comments/Explanation
General Health (Do you feel well?)			
Women: Post menopausal? Irregular Bleeding? Normal periods? Are you pregnant?			
Heartburn, belching, nausea, bloated stomach or difficult swallowing? If yes, please explain.			
Change in bowel habits?			
Loss of appetite? More than 5 pound weight change in the last year?			
Abdominal pain, pressure or discomfort?			
Urinary problems (pain, burning or frequency? Incontinence?			
Headaches, dizziness, loss of consciousness or poor memory?			
Chest pain or shortness of breath, at rest or with exercise? Lung congestion?			
Changes in eye sight or eye pain?			
Loss of hearing? Ear or sinus pain? Ringing or buzzing in ears?			
Changes on self breast exam?			
Rash, skin discoloration or changes in birthmarks or moles?			
Bruising or bleeding?			
Bone or joint pain, muscle aches or loss of strength?			
Increased thirst, fatigue, loss of hair or dry skin?			
Swelling in neck, armpit or groin?			
Depression or anxiety? Trouble sleeping?			
Allergies (food, drug or environmental)			
Do you: Smoke? Drink alcohol? Use marijuana, cocaine or other street Drugs? Drink caffeine?			
Do you follow a special diet? Do you add salt at the table?			
Do you feel safe in your home environment?			
Have you ever had a blood transfusion?			

(over)

Please indicate the year of your most recent immunization:

Tetanus		**Measles/Mumps/Rubella**	
Influenza (Flu Shot)		**Hepatitis B**	
Pneumonia (Pneumovax)		**Tuberculin Test (PDD)**	

Past Health History

Please list any hospitalization or operations you have had. Include one-day surgeries.

DATE	TYPE OF ILLNESS OR SURGERY	NAME OF HOSPITAL	LOCATION OF HOSPITAL

Check box if you have NOW or have ever had any of the following conditions/illnesses:

□Cancer: Type_____

□Abnormal Chest X-ray	□Eating Disorder	□ Migraine Headaches	□ Rheumatic fever
□Alzheimer's Disease	□Gout	□ Mononucleosis	□ Seizures or Epilepsy
□Anxiety, Panic Attacks	□Heart Attack	□ Multiple Sclerosis	□ Stomach ulcers
□Arthritis	□Heart Disease	□Osteoporosis	□Stroke
□Asthma	□Heart Murmur	□Pancreatitis	□Thyroid Disease
□Blood/Bleeding Disorders	□Hearing Loss	□Parkinson's Disease	□Tuberculosis
□Cataracts/Glaucoma	□Hepatitis	□Prolonged Fatigue	□Unexplained Fevers
□Chronic Bronchitis	□Hernia	□Prostate Disease	□_____
□Chronic Lung Disease	□High Blood Pressure	□Pneumonia	□_____
□Circulation Problems	□Infertility	□Rectal Bleeding	
□Depression	□Kidney Disease	□Venereal Disease (Sexually Transmitted Disease)	
□Diabetes	□Liver Disease	□Blood, albumin (protein) or sugar in urine	

Family Health History

	Age(s)	Present health or if deceased, cause of death	Age at death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

Please place the appropriate letter in the space to indicate if blood relatives have or had any of the following problems:

M-mother F-father S-sister B-brother G-grandparent C-children

___Heart Disease	___Leukemia	___Crippling arthritis	___Suicide attempt
___Stroke	___Lung Cancer	___Lupus	___Nervous breakdown
___High blood pressure	___Cervical Cancer	___Glaucoma	___Gout
___High Cholesterol	___Breast Cancer	___Diabetes	___Thyroid problems
___Sudden Death	___Uterine Cancer	___Alcoholism	___Seizures/Fits
___Bleeding Disorder	___Colon Cancer	___Nervous Disorder	___Epilepsy
___Sickle cell disease	___Cancer (other)	___Depression	___Kidney Disease

Signature of Patient_____

Reviewed by _____Date _____