Doylestown Health Physicians

General, Vascular & Breast Surgery

Date _____

Patient Name _____ **Date of Birth** _____

Address _____

Phone # _____ **Cell Phone #** _____

Emergency Contact _____ **Relationship** _____

Referring Physician _____ **Phone #** _____

Family Physician _____ **Phone #** _____

Employer _____ **Occupation** _____

Race _____ **Ethnicity** _____ **Language** _____

Male ____ **Female** _____ **Email** _____

REASON FOR VISIT _____

Height_____ **Weight**_____ **BP**_____ **Temp.**_____

Please list all medications:

☐ See Attached List

Name	Dosage	Frequency

Please list all allergies (include any medications or other products) **LATEX ALLERGY Yes or No**

Drug	Reaction

Review of Symptoms (circle appropriate symptoms)

Constitutional	Fever, chills, unexplained weight loss
Eyes	Blurred vision, double vision, eye pain, loss of vision
Respiratory	Shortness of breath, cough, wheezing
Cardiovascular	Chest pain, palpitations
Neurologic	Headaches, dizziness, numbness, weakness, change in mental status
Hematologic	Bleeding disorder, excessive bleeding, bruising
Gastrointestinal	Abdominal pain, constipation or diarrhea, change in bowel habits, blood in stool
GU	Blood in urine, painful urination
Musculoskeletal	Lower back pain, leg swelling, leg pain
Endocrine	Diabetes, thyroid disorder

-over please-

Patient Medical History (please circle all that apply)

Diabetes Mellitus	Type I, Type II, Insulin dependent, oral medications, diet control
Hypertension	
Lung Disease	Emphysema, Asthma, Chronic Obstructive Pulmonary Disease, Pneumonia
Heart Disease	Myocardial Infarction (Heart Attack), Angina, Congestive Heart Failure, Cardiac Arrhythmias, Heart Murmur, Valvular Heart Disease
Liver/Gall Bladder Disease	Hepatitis, Gall Stones, Pancreatitis, High Cholesterol
Gastrointestinal Disease	Ulcer Disease, Inflammatory Bowel Disease, Irritable Bowel Syndrome, Diverticulosis, Diverticulitis, Colon Polyps, Colon Cancer
Kidney Disease	Kidney Stones, Recurrent Infections
Bleeding Problems	Deep Venous Thrombosis (Blood Clots), Pulmonary Embolism, Superficial Thrombophlebitis
Endocrine Diseases	Hyperthyroidism, Hypothyroidism, Thyroid Cancer, Hyperparathyroidism, Adrenal problems

Please list any other medical problems:

_____

_____

Please list all previous operations:

Operation	Operation Approximate Year (if known)

Family History

Is there any history of cancer in your family? ☐ Yes ☐ No

If yes, please list family member and type of cancer.

Family Member _____ Type of Cancer _____

_____

Is there a history of early Heart Disease in the family? ☐ Yes ☐ No

For Breast Patients

Number of Children? _____ Age at first menstrual period? _____ Age at the birth of your first child? _____

Did you: ☐ breast-feed or ☐ bottle feed?

Social History

Smoking History

Are you currently smoking? ☐Yes ☐ No If no, are you are former smoker? ☐Yes ☐ No

Year/Age you stopped_____

Complete the following even if currently not smoking:

Packs per day _____ Number of smoking years _____

Alcohol History

Average number of drink per week _____

Breast Screening mammogram within the past year **YES/NO If yes, when?**_____

Flu vaccine **YES/NO if yes, when?**_____ Pneumococcal vaccine **YES/NO if yes when?**_____

Colorectal Screening within the past 5 years **YES/NO If yes, when?** _____

Circle One Colonoscopy Sigmoidoscopy Hemoccult

Have you fallen in the past year? **YES/NO**

Do you have Sleep Apnea? **YES/NO**