GULF COAST SURGICAL CENTER
Confidential Patient Medical History

Patient Name: ______________________________ DOB: ______________

Height: ____' ____" Weight: _____lbs. Age: _____ Occupation: ______________

Are you currently pregnant? Yes / No

Your Primary Care Physician's Name: ______________________________

Your Cardiologist's Name: ______________________________

Past Medical History: Have you ever had any of the following? Circle that all apply

ADD	Bladder Infections	DVT (blood clot)	High Blood Pressure	Mitral Valve Prolaspe	Sickle Cell
AIDS OR HIV+	Bleeding Tendency	Epilepsy	High Cholesterol	Pneumonia	Sleep Apnea
Anemia	Blood Transfusions	Fibromyalgia	Infectious Mono	Polio	Stents in Heart
Arthritis – Osteo	Bronchitis	Glaucoma	Kidney Disease	Restless Leg Syndrome	Stroke
Arthritis – Rheumatoid	Cancer	Gout	Low Blood Pressure	Rheumatic Fever	Thyroid Disease
Asthma	Depression/Anxiety	Heart Disease	Lupis	Scarlet Fever	Tuberculosis
Back Trouble	Diabetes	Hepatitis	Migraine Headaches	Seizures	Ulcers

Other: ______________________________

Past Surgical History

Surgery: ______________________ Facility: ______________________
Surgery: ______________________ Facility: ______________________
Surgery: ______________________ Facility: ______________________
Surgery: ______________________ Facility: ______________________
Surgery: ______________________ Facility: ______________________
Surgery: ______________________ Facility: ______________________

Current Medications & Supplements

Drug Name: ______________________ Drug Name: ______________________
Drug Name: ______________________ Drug Name: ______________________
Drug Name: ______________________ Drug Name: ______________________
Drug Name: ______________________ Drug Name: ______________________
Drug Name: ______________________ Supplement Name: ______________________
Drug Name: ______________________ Supplement Name: ______________________

Allergies:

Medication Allergies: ______________________ Describe Reaction: ______________________
Medication Allergies: ______________________ Describe Reaction: ______________________
Medication Allergies: ______________________ Describe Reaction: ______________________

Food Allergies: ______________________ Describe Reaction: ______________________

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Patient Social History:

Tobacco Use: Never Former Occasional Use Daily Use _______________ (amount)
Alcohol Use: Holidays Maybe None Past Year 1 per day 2 -3 per day 4-5 per day 6+ day
Use of Recreational Drugs: Never Previous Current ____ (list)

Family Medical History:

	Known Conditions or Diseases of Immediate Family:	**If Deceased, Cause of Death:**
Father:	______________________________	____________________
Mother:	______________________________	____________________
Siblings:	______________________________	____________________

Review of Systems: Please indicate if you have any of the following – circle all that apply

Musculoskeletal
Joint Pain
Joint stiffness or swelling
Weakness of muscle or joints
Muscle pain or cramps
Back Pain
Cold extremities
Difficulty in walking

Cardiovascular
Heart trouble
Chest pains or angina pectoris
Palpitation
Shortness of breath while walking
Swelling of feet, ankles or hands

Constitutional Symptoms
Bad general health lately
Recent weight change
Fever
Fatigue
Headaches

Ears/Nose/Mouth/Throat
Hearing Loss or Ringing
Earaches or drainage
Chronic sinus problems
Nose Bleeds
Bleeding Gums
Sore throat or voice change
Swollen glands in neck

Genitourinary
Frequent urination
Burning of painful urination
Blood in urine
Incontinence or dribbling

Integumentary (skin, breast)
Rash or itching
Changes in skin color
Varicose veins

Neurological
Light headed or dizzy
Numbness or tingling sensations
Tremors
Paralysis

Endocrine
Excessive thirst or urination
Heat or cold intolerance
Skin becoming dryer

Hematologic/Lymphatic
Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Enlarged glands

Respiratory
Chronic or frequent coughs
Spitting up blood
Shortness of breath
Wheezing

Gastrointestinal
Loss of appetite
Nausea or vomiting
Frequent diarrhea
Constipation
Rectal bleeding, bleeding in stool
Abdominal pain

Psychiatric
Memory loss or confusion
Nervousness
Depression
Insomnia

Other: Information your doctor might need: ____
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