

Southern Surgical Associates, PA
Medical History Form

Patient Name: _____ Date of Birth _____ Age _____

Race _____ Sex _____ Insurance _____ **HT _____ WT _____ BMI _____ IBW _____ -For office use ONLY**

Primary Care Physician _____ Referring Physician _____

Current/Past Medical History: *Circle all that you have or have had in the past*

| | | | | | |
|----------------------------|----------------------|---------------------|----------------------------------|-------------------------------|-----------------------------|
| Cardio-Pulmonary: | Asthma | High Blood Pressure | Sleep apnea with C-Pap or Bi-Pap | Venous Insufficiency | Heart Attack, Date _____ |
| | PE/DVT | | | | |
| | Emphysema | Heart Disease | COPD | Irregular heart beat | Shortness of Breath |
| | High Cholesterol | Sarcoidosis | CHF | Chest pain | Heart Murmur |
| Gastrointestinal: | Ulcer | Liver Disease | Reflux/ Hiatal Hernia | Barrett's Esophagus | Hepatitis _____ |
| | Diverticulitis | Pancreatitis | Cirrhosis | IBS | Nausea/Vomiting |
| Hematology: | Anemia | Bleeding disorders | Use Blood Thinners: _____ | | |
| Endocrine/Renal: | Diabetes | Kidney Failure | Hypothyroid | Hyperthyroid | |
| Muscular/ Skeletal: | Fibromyalgia | Arthritis | Back Pain | Pain in weight bearing joints | Use cane/walker/wheel-chair |
| | Gout | Lupus | | | |
| Neurological: | Seizures, date _____ | | Migraines | Anxiety | |
| | Stroke, date _____ | | Depression | Bipolar | |
| Cancer: | Breast | Prostate | Colon/Gastric | Leukemia/ Lymphoma | Other _____ |
| GE: | PCOS | Irregular Menses | Stress Incontinence | Infertility | |

Past Surgical History: *Circle all that you have had, list any other surgery you may have had.*

| | | | | |
|-------------------------|------------------|------------------------|--------------|----------------|
| Appendectomy | Colon Resection | Hemorrhoidectomy | Cardiac Cath | Tubal Ligation |
| Lap/Open Gallbladder | Hernia Repair | Cardiac Bypass _____yr | Hysterectomy | C-section |
| Nissen (reflux surgery) | Hip Replacement | Mastectomy | Cataract | Carpel Tunnel |
| Gastric Bypass | Knee Replacement | Tonsillectomy | Back Surgery | Other _____ |
| CABG | Pace Maker | Defibrillator | | |

ALLERGIES: None Drug: _____ Reaction: _____

| Name of Medication | Dosage/Frequency | Name of Medication | Dosage/Frequency |
|--------------------|------------------|--------------------|------------------|
| | | | |
| | | | |
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| | | | |
| | | | |

Family History: *Please list any health problems, age, and if deceased, cause of death*

Father: _____
 Mother: _____
 Brother: _____
 Sister: _____

- Gastric Bypass
- Gastric Band
- Sleeve Gastrectomy
- Undecided

Social History: *Please circle all that apply*

Tobacco: Never Daily, Type and Amount _____ Quit, _____yr
 Alcohol: Never Rarely Moderate Frequent
 Street Drug Use: No Yes, Type/Frequency _____
 Marital Status: Single Married Divorced Separated Widowed
 Occupation: _____ Full-time Part-time

Please choose your surgeon:

Dr. Naziri
 Dr. Mann

Patient Signature: _____ Date: _____ Reviewed by: _____ Date: _____