Falls Canyon Surgical Associates

Patient Name: _____DOB _____ Date: _____

Reason for Visit: _____

Have you **EVER** been **diagnosed by a physician** with any of the following?

- ☐ Abnormal Mammogram
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Carotid Stenosis
- ☐ Claudication
- ☐ Colon Polyps
- ☐ Colon Cancer
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart murmur-Previous or Current
- ☐ Heart Valve Replacement
- ☐ Hepatitis (Type:)
- ☐ Hiatal Hernia
- ☐ HIV
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension
- ☐ Irritable Bowel (IBS)
- ☐ Joint Replacement
- ☐ Kidney/Renal Failure
- ☐ Liver Disease
- ☐ MRSA
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Rectal Cancer
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Sleep Apnea/CPAP y/n
- ☐ Stomach Cancer
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ UTI's (Frequent)

Surgical History (Please list dates of **ALL** prior surgical procedures and name of performing doctor if available. All surgeries are relevant to your medical care.)

Gallbladder	_____	Colon Resection	_____
Heart Bypass	_____	Appendectomy	_____
Tonsillectomy	_____	Ulcer Surgery	_____
Adenoidectomy	_____	Breast Surgery	_____
Hernia Repair	_____	Heart Valve	_____
Pacemaker	_____	Hysterectomy	_____

Other Surgery _____

Screening/Diagnostic Tests (Have you **EVER** had any of the following tests?)

Colonoscopy	YES/NO	When _____	Where _____
Upper Endoscopy	YES/NO	When _____	Where _____
Mammogram	YES/NO	When _____	Where _____
Breast Ultrasound	YES/NO	When _____	Where _____

Family History Has anyone in your family ever had any of the following? If so**,** please list their relation to you **and** which side of the family. **(Paternal or Maternal**)

Colon Cancer	_____	Bleeding Disorder	_____
Colon Polyps	_____	Heart Disease	_____
Rectal Cancer	_____	Celiac Disease	_____
Uterine Cancer	_____	Ulcerative Colitis	_____
Ovarian Cancer	_____	Crohn's Disease	_____
Pancreatic Cancer	_____	Liver Disease	_____
Prostate Cancer	_____	Hypertension	_____
Stomach Cancer	_____	Diabetes	_____
Breast Cancer	_____	**Other Med. Condition**	_____

Patient History Cont.

Social History

□ Current Smoker □ Never Smoker □ Former Smoker: Quit: _____

□ Current Alcohol Use/Frequency: _____ □ Former Alcohol Use/Quit: _____

□ Current Drug Use Type: _____ □ Former Drug Use Type/Quit: _____

Are you **CURRENTLY** experiencing any of the following?

Systemic
□ Weight Loss
□ Weight Gain
□ Fever
□ Fatigue

Hematologic
□ Easy Bruising
□ Bleeding Tendency

Eyes
□ Blurred Vision
□ Vision Loss

ENT
□ Loose Teeth
□ Frequent Nosebleeds
□ Hearing Loss

Neck
□ Neck Pain
□ Neck Stiffness

Cardiac
□ Irregular Heartbeat
□ Chest Pain
□ Chest Pain w/ Exercise
□ Evaluation for Chest Pain

Pulmonary
□ Wheezing
□ Shortness of Breath
□ Chronic Cough

Gastrointestinal
□ Abdominal Pain
□ Acid Regurgitation
□ Belching
□ Black/Tarry Stool
□ Bloating
□ Blood In Stool
□ Change in Bowel Habit
□ Constipation
□ Decreased Appetite
□ Diarrhea
□ Difficulty Swallowing
□ Heartburn
□ Jaundice
□ Nausea
□ Rectal Bleeding
□ Spitting up Blood
□ Vomiting

Genitourinary
□ Blood In Urine
□ Dark Urine
□ Pain with Urination

Women Only
□ Breast Lump
□ Breast Feeding
□ Pregnancy

Musculoskeletal
□ Back Pain
□ Bone Pain
□ Limb Swelling

Neurologic
□ Fainting
□ Numbness
□ Weakness

Endocrine
□ Excess Thirst
□ Excess Urination
□ Intolerance to Temperature

Skin
□ Itching
□ Lump
□ Rash
□ Ulcer

Psychological
□ Anxiety
□ Depression

Pharmacy Preference
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Cardiologist_____

Pulmonologist_____

Other Specialist_____