

South Carolina Obesity Surgery Center

MEDICAL HISTORY

Patient's Full Name: _____ Age: _____ Date _____

Referring Doctor: _____ Regular Doctor: _____

Reason for Visit: _____

Past Medical History: Do you have or have you ever been treated for (check all that apply)

Cardiac

- Heart Attack
- Coronary artery disease
- High Blood Pressure
- Heart Failure
- Irregular heart beat
- High cholesterol

Pulmonary

- Emphysema
- Asthma
- Chronic Bronchitis
- Sleep Apnea

Gastrointestinal

- Hepatitis
- Chronic heart burn
- Ulcers
- Diverticulosis
- Polyps

Genitourinary

- Kidney failure
- Kidney stones
- Kidney infections
- Chronic urinary infection

Endocrine

- Diabetes
- Thyroid problems

Neurological

- Stroke
- Seizures

Hematological

- Anemia
- Blood clots
- HIV

Other

- _____

Musculoskeletal

- Arthritis – Joints
- Arthritis – Back
- Disc problems – Back
- Osteoporosis
- Gout
- Varicose Veins

Psychological

- Depression

Eyes

- Glaucoma
- Blindness

Cancer

- Type _____
- Date _____

Past Surgical History: Please include date

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> C-Section |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Hysterectomy (Uterus) |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Back (Disc) |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Other _____ |

Medication Allergies: Please include type of reaction

Family Medical History: Please list medical problems not names

Father _____ Mother _____

Grandparents _____

Brothers _____

Sisters _____

Social History: Marital Status: M S W D Current employment _____ Retired: Y N

Tobacco: None Cigarettes Cigars Pipe PPD _____ No Yrs. _____ Quit Date _____

Alcohol: No Yes Amt _____ Are you a Jehovahs' Witness? No Yes

Physical Activity: Regularly Occasionally Rarely Type of activity _____

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Review of Systems: Check all that apply

HEENT

- Frequent headache
- Change in vision
- Dizziness
- Change in hearing
- Ringing in ears

Cardiac

- Chest pain
- Racing pulse
- Leg swelling
- Lightheadedness

Pulmonary

- Shortness of Breath
 - At rest
 - With exertion
- Cough
- Wheezing

Gastrointestinal

- Nausea/Vomiting
- Difficulty swallowing
- Indigestion
- Diarrhea
- Constipation
- Blood in stool

Genitourinary

- Blood in urine
- Painful urination
- Night time urination
- Incontinence

Musculoskeletal

- Muscle weakness
- Joint pain
- Joint swelling
- Back pain

General

- Fever / chills
- Weight loss / gain
- Night sweats
- Hotter than usual
- Colder than usual
- Easy bruising
- Easy bleeding
- Daytime sleepiness
- Snoring
- Waking up at night

OFFICE USE ONLY

Physical Exam:

Height: _____ Weight: _____ BMI: _____ BP: _____ HR: _____

HEENT: WNL _____

Neck: WNL _____

Heart: WNL _____

Lungs: WNL _____

Abd: WNL _____

Ext: WNL _____