

NAME: \_\_\_\_\_

REFERRING MD: \_\_\_\_\_ DATE: \_\_\_\_\_

**LIST ALL MEDICATIONS (including dosages and aspirin)**

**DRUG ALLERGIES  
(including IV contrast & latex)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY: (Please check yes/no and designate family member affected)**

	YES / NO	Affected Family Member
Heart Disease	YES / NO	_____
High Blood Pressure	YES / NO	_____
Stroke	YES / NO	_____
Cancer	YES / NO	_____
Diabetes	YES / NO	_____
Bleeding Disorder	YES / NO	_____
Anesthesia Problem	YES / NO	_____

**PRIOR SURGERIES: (List dates, places, and surgeries performed)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**

MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_

SMOKE: YES / NO if yes, how many \_\_\_\_\_ for how long \_\_\_\_\_

ALCOHOL: YES / NO if yes, how many \_\_\_\_\_ how often \_\_\_\_\_

CAFFEINE: YES / NO if yes, how many \_\_\_\_\_ how often \_\_\_\_\_

\_\_\_\_\_

MILWAUKEE SURGICAL SPECIALISTS, S.C.

**REVIEW OF SYSTEMS: (please check yes/no if you have had these symptoms in the last five years and note any date or workup that has been done)**

GEN: fevers/night sweats/chills/weight loss	YES / NO	_____
NEURO: headaches/dizziness/blurred vision	YES / NO	_____
CARDIAC: chest pain	YES / NO	_____
Shortness of breath	YES / NO	_____
Palpitations	YES / NO	_____
Edema or swelling in ankles	YES / NO	_____
Walk a block with difficulty	YES / NO	_____
Flight of stairs with difficulty	YES / NO	_____
Arrhythmias/atrial fibrillation	YES / NO	_____
Murmurs	YES / NO	_____
Increased blood pressure	YES / NO	_____
Increased cholesterol	YES / NO	_____
RESP: cough	YES / NO	_____
Wheezing/asthma	YES / NO	_____
GI: abdominal pain	YES / NO	_____
Nausea/vomiting	YES / NO	_____
Colonoscopy	YES / NO	_____
Ulcers	YES / NO	_____
Heartburn	YES / NO	_____
Diarrhea/constipation	YES / NO	_____
Bloody stool	YES / NO	_____
NM: bone pain/arthritis	YES / NO	_____
GU: urinary tract infections/incontinence	YES / NO	_____
Burning with urination	YES / NO	_____
HEME: history of bleeding disorder	YES / NO	_____
Stroke/clot/blood transfusion	YES / NO	_____
PSYCH: anxiety/depression	YES / NO	_____
ENDO: thyroid abnormality/diabetes	YES / NO	_____
SKIN: new rashes/lesions	YES / NO	_____

**PLEASE LIST ANY OTHER SIGNIFICANT MEDICAL PROBLEMS:**

_____	_____
_____	_____
_____	_____
_____	_____