Name: _____ Date of Birth: _____

Surgery New Patient Information

Date: _____

Primary Care Physician: _____

Reason for Today's Visit: _____

Medical History: Please circle any health condition that applies to you and specify/comment if needed. If you have any questions, please ask a member of our staff for assistance. Thank you.

Medical History (For "Other," Please Specify)	**Specify/Comments**
Alcohol/Drug Problem	
Breast Lump, Other breast problem	
Cardiac Congestive Heart Failure, Heart attack, Heart Disease, High blood pressure, High cholesterol, Valve problem, Other	
Cancer Brain, Breast, Cervical, Colon, Lung, Ovarian, Prostate, Rectal, Skin, Thyroid, Uterine, Other	
Digestive/Stomach Barrett's Esophagus, GERD, Hernia, Intestinal problem, Liver Disease, Ulcer, Other	
Endocrine Diabetes, Thyroid Disease, Other	
Eyes/Ears/Nose/Throat	
Hematology Anemia, Bleeding disorder, Clotting disorder, Other	
Immune Disorder AIDS, HIV, Lupus, Other	
Kidney Disease, Kidney stone, Other kidney problem	
Musculoskeletal Arthritis/Joint problem, Hernia, Osteoporosis/Osteopenia, Other	
Neurological Nerve Disease, Stroke, Other	
Psychiatric Anxiety, Depression, Other	
Respiratory Asthma, COPD, Other	
Skin Eczema, Psoriasis, Other	
Urinary / Reproductive Abnormal pap test, Bladder problem, Menstrual abnormality, Prostate problem, Sexually transmitted infection, Other	
Vascular (Arteries, veins)	
Other Medical History:	

CAPE REGIONAL PHYSICIANS ASSOCIATES

CRPA Surgery

Name: _____ Date of Birth: _____

Medication: Please list all medications with dose and frequency.
(Please include non-prescription medications, vitamins, and supplements)

Medication	**Dose**	**Frequency** (i.e., how many times daily?)	**Prescribed By**

Pharmacy: Where would you like us to send your prescriptions?
Local pharmacy name, location: _____
Mail order pharmacy name: _____

Do you take any of the following blood thinners? (Circle any that apply):
Aspirin, Ibuprofen-based products (Ex. Motrin, Advil), Coumadin, Lovenox, Plavix, Xarelto, Pradaxa

Do you need any medication refills today? If so please list:

_____

Allergies: Please list ALL medication, food, and/or environmental allergies, and specify reaction type that occurs (i.e. rash, itching).

Have you ever had an anaphylactic reaction (severe, near deadly reaction)?: (Circle) Yes / No

Family History: Please note any serious family medical history

Father:	Father's Father:
Mother:	Father's Mother:
Brother:	Mother's Father:
Sister:	Mother's Mother:
Other Family History:	

Social History: (Please circle the following that apply to you):
Are you: Single Married Divorced Other
Are you sexually active? Yes No
What is your employment/occupation? _____
Please outline your use of the following products, past or present:

Product	**Current Use? Yes/No**	**Daily Amount**	**Weekly Amount**	**Past Use? Yes/No**
Tobacco				
What did you use to smoke? ____ cigarettes, ____ pipe, ____ cigars, ____ chewing tobacco				
Alcohol				
Recreational Drugs				
Caffeine				

Do you use other forms of nicotine products? (circle) smokeless tobacco, electronic cigarettes? _____

CAPE REGIONAL PHYSICIANS ASSOCIATES

CRPA Surgery

Name: _____ Date of Birth: _____

Immunization:

Immunization up to date?	Yes/No	When?
Flu Vaccine this year?	Yes/No	
Pneumonia	Yes/No	
Tetanus	Yes/No	
Pertussis	Yes/No	
Zostavax	Yes/No	
History of Blood Transfusion?	Yes/No	

Do you have a Living Will/Advance Directive? _____

Health Maintenance: Please note the most recent date you received any of the below health services.

Service	**Date (Month/Year)**	**Physician**
Yearly Physical		
Eye Exam (If **Dilated** Eye Exam, please specify)		
Dental Exam		
Pap Smear		
Prostate Exam		
Mammogram		
Colonoscopy		
Diabetic Foot Exam		

Recent Diagnostic Studies: (within the last 3 years)

1. Heart Testing (Type / Where / When) _____
2. Lung Testing (Type / Where / When) _____
3. X-Ray (Where / When / Specify Body Part) _____
4. Ultrasound (Where / When / Specify Body Part) _____
5. CT (Where / When / Specify Body Part) _____
6. MRI (Where / When / Specify Body Part) _____
7. Biopsy (Where / When / Specify Body Part) _____
8. Other (Type / Where / When) _____
9. Most Recent Blood Testing/Labs (Where / When) _____

Past Surgical History/Past Procedures:

_____

_____

Recent Hospitalization(s):

_____

_____

_____

Current and/or Previous Medical Specialists: (Name/Specialty)

_____

_____

_____

Signature of patient or guardian Printed name of patient or guardian Date