Florida Surgical Weight Loss Centers

Patient History

Patient Name: _____ **DOB** _____ **Age** _____ **Date Completed**_____

Doctor(s) who sent you: _____

I. Chief Complaint: (Reason for your visit) _____

II. History of Present Illness or Injury

Is this illness/ injury employment related? ☐ **Yes** ☐ **No**

Please answer all questions. If one does not apply to you, please write N/A (not applicable).

- **Location:**_____ *(Where on the body symptom occurs)*
- **Duration:**_____ *(How long have you had symptom/pain? How long does it last?*
- **Severity:** _____ *(Severe, worse, slightly Symptom/pain scale 1-10*
- **Quality:** _____ *(Character of symptoms/pain . . burning, gnawing, stabbing, etc.)*
- **Timing:** _____ *(When symptoms occur . . after meals or exercise, etc.)*
- **Context:** _____ *(Situation associated with symptom)*
- **Modifying Factors:** _____ *(Things to make symptoms better or worse)*
- **Associated Signs/Symptoms:** _____ *(Other things that happen when this symptom occurs)*

III. Past, Family and Social History

1. Medical History: *(Please circle **Yes** if <u>you</u> have any of the following medical problems. Circle **No** if you do not have the problem.)*

High Blood Pressure	Yes	No	Stroke	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Hepatitis	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Type: _____		
Angina/Chest Pain	Yes	No	Blood clots/DVT	Yes	No	Heart Attack	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No	Date of attack _____		
Tuberculosis	Yes	No	**Other Problems**: _____					

Drug Allergies: _____

PHARMACY: _____

Medications: ☐ See attached Med List ☐ No Medication at this time

Drug Name	Directions	Prescribed by
	Take _____ tab/cap ____ times per day	
	Take _____ tab/cap ____ times per day	
	Take _____ tab/cap ____ times per day	
	Take _____ tab/cap ____ times per day	
	Take _____ tab/cap ____ times per day	

List all Hospitalizations / Surgeries / Injuries

_____ _____

_____ _____

_____ _____

2. Family History: *(Please list any known medical problems in your relatives)*

Father: _____ Mother: _____

Siblings: _____ Others: _____

3. Social History Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use ☐ Never ☐ Quit/ Year _____ ☐ Current smoker / packs per day _____ ☐ Other Tobacco

Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily/ How Much? _____

Drug Use ☐ Never ☐ Type & Frequency _____

Occupation ☐ Retired ☐ Current Occupation _____

Continued on Back

Patient History (Continued)

Patient Name _____ **DOB** _____ **Date Completed** _____

Advance Directive/Living Will ☐ **No** ☐ **Yes**

Healthcare Surrogate/Power of Attorney ☐ **No** ☐ **Yes Name:** _____

Patient Statement **To the best of my knowledge, the above information is accurate and complete.**

Signed: _____ **Date** _____