Name________________________ DOB__________

SURGICAL ASSOCIATES, PC
INTAKE SHEET

In order to allow us to serve you better, please answer the following questions:

REASON FOR SEEING THE DOCTOR TODAY ___________________________________
____

Past Medical History

1a. List any previous operations and year performed: None: _____

1b. List any previous joint replacement surgeries and year performed: None: _____

2. List any hospitalizations for illnesses (I.E. pneumonia) and year occurred: None: _____

3. List any current medical conditions you are being treated for:

Review of Systems: Do you have or have you been treated for in the past:

Condition	Y / N	Condition	Y / N
Unexplained weight loss	Y___ N___	Skin cancer	Y___ N___
Recent Fever	Y___ N___	Breast problems	Y___ N___
Hearing loss	Y___ N___	Stroke	Y___ N___
Hoarseness	Y___ N___	Seizure	Y___ N___
Heart Disease	Y___ N___	Sleep Apnea	Y___ N___
Rhythm problems	Y___ N___	Brain Injury	Y___ N___
Congestive Heart Failure	Y___ N___	Chronic depression	Y___ N___
Asthma	Y___ N___	Anxiety	Y___ N___
Chronic cough	Y___ N___	Diabetes	Y___ N___
Shortness of breath on exertion	Y___ N___	Smoker	Y___ N___
High Blood Pressure	Y___ N___	Hepatitis	Y___ N___
Thyroid Disease	Y___ N___	Blood in Stools	Y___ N___
Deep Vein Thrombosis	Y___ N___	Chronic Reflux	Y___ N___
Blood clotting problems	Y___ N___	Kidney problems	Y___ N___
Bleeding Problems	Y___ N___	Bladder problems	Y___ N___
Seasonal Allergies	Y___ N___	Arthritis	Y___ N___
Auto immune disorder	Y___ N___		

Personal Medication Organizer

Health Care Provider's Information

Primary Physician ____ Phone # _________________

Specialist(s) ____ Phone # _________________

Pharmacy: ____ Phone # _________________

Allergies ____

Do you have an existing pain contract? Yes_____No_____

Drug Name	Prescribing Physician	Strength (Dosage)	How Often?	Why do you take this is?

Social History

Do you smoke? Yes _____ No _____ If yes, how many packs per day?_______
Do you drink alcohol? Yes _____ No_____ If yes, how many drinks per week?______

Occupation: ________________________________

Marital Status - (circle one) M S D W

Family History

a) Please check:

	Living	Age	Deceased/Cause	Age
Father	_____	_____	________________	_____
Mother	_____	_____	________________	_____
Brother	_____	_____	________________	_____
Sister	_____	_____	________________	_____

b) Do you have a family history of bleeding problems? Yes_____No_____

c) Do you have a history of cancer in your immediate family? Yes_____No_____
If yes, please list family member and type of cancer:

d) Do you have a history of rare family illness? Yes_____No_____

e) Prominent Family Medical Problems ____

____

If you are over 65 have you had any falls in the past year? Yes_____No_____ NA______
If yes, how many? ________ Were you injured? Yes_____No_____

PATIENT SIGNATURE:____

DATE: _________________________