

**Coastal Surgical Specialists, P.C.**  
**PATIENT HISTORY**

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital status: M S D W      Number of children/ages: \_\_\_\_\_ / \_\_\_\_\_

Who referred you? \_\_\_\_\_ Family doctor: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

How long has this been bothering you? \_\_\_\_\_

Please list routine medications and dosages: \_\_\_\_\_

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

Are you allergic to any medications? Please list: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:**

Father      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Mother      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Brother      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Brother      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Brother      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Sister      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Sister      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Sister      Living: Y / N      Age \_\_\_\_\_      Health status: \_\_\_\_\_

Is there any history in your immediate family of:

colon cancer?      Y / N

colon polyps?      Y / N

breast cancer?      Y / N

heart disease?      Y / N

diabetes?      Y / N

other cancer?\*      Y / N

Who / Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

other chronic illness?\* **Y / N** \_\_\_\_\_  
 \* please specify type of other cancer / illness \_\_\_\_\_  
 \_\_\_\_\_

**Vital Signs:** T: \_\_\_\_\_ B/P: \_\_\_\_\_ P/R: \_\_\_\_\_ (done by the MA)

**Surgeon's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PERSONAL HISTORY:**

Please list any health problems: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any surgeries with dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you smoke? **Y / N** How Many Packs/Day: \_\_\_\_\_

How much alcohol do you consume? \_\_\_\_\_

Do you have any personal history of (please check **all** that apply)

**CONSTITUTIONAL:**

- \_\_\_\_\_ fever / chills
- \_\_\_\_\_ night sweats
- \_\_\_\_\_ fatigue
- \_\_\_\_\_ weight loss/gain

**EYES:**

- \_\_\_\_\_ blurred vision
- \_\_\_\_\_ blindness
- \_\_\_\_\_ blindness one eye

**EAR/NOSE/THROAT:**

- \_\_\_\_\_ sinusitis
- \_\_\_\_\_ sore throat
- \_\_\_\_\_ hoarseness
- \_\_\_\_\_ hearing loss
- \_\_\_\_\_ difficulty swallowing

**CARDIOVASCULAR:**

- \_\_\_\_\_ heart attack
- \_\_\_\_\_ high blood pressure
- \_\_\_\_\_ chest pain
- \_\_\_\_\_ irregular rhythm

**RESPIRATORY:**

- \_\_\_\_\_ shortness of breath
- \_\_\_\_\_ chronic cough
- \_\_\_\_\_ productive cough
- \_\_\_\_\_ emphysema
- \_\_\_\_\_ asthma
- \_\_\_\_\_ coughing blood

**GASTROINTESTINAL:**

- \_\_\_\_\_ nausea
- \_\_\_\_\_ vomiting
- \_\_\_\_\_ vomiting blood
- \_\_\_\_\_ chronic heartburn
- \_\_\_\_\_ constipation
- \_\_\_\_\_ diarrhea
- \_\_\_\_\_ blood in stool
- \_\_\_\_\_ black tarry stool
- \_\_\_\_\_ clay colored stool
- \_\_\_\_\_ hemorrhoids
- \_\_\_\_\_ colorectal polyps
- \_\_\_\_\_ ulcers
- \_\_\_\_\_ Crohn's

- \_\_\_\_\_ colitis
- \_\_\_\_\_ irritable bowel
- \_\_\_\_\_ hepatitis
- \_\_\_\_\_ weight gain

**GENITOURINARY:**

- \_\_\_\_\_ nighttime voiding
- \_\_\_\_\_ blood in urine
- \_\_\_\_\_ change in urine color
- \_\_\_\_\_ urine stream change
- \_\_\_\_\_ prostate disease
- \_\_\_\_\_ change in urine
- \_\_\_\_\_ muscle weakness

**SKIN:**

- \_\_\_\_\_ allergies
- \_\_\_\_\_ skin rashes
- \_\_\_\_\_ moles

**BREAST:**

- \_\_\_\_\_ breast lumps
- \_\_\_\_\_ breast pain
- \_\_\_\_\_ nipple discharge

**NEUROLOGIC:**

- \_\_\_\_\_ chronic headaches
- \_\_\_\_\_ dizziness
- \_\_\_\_\_ stroke
- \_\_\_\_\_ paralysis
- \_\_\_\_\_ shakiness
- \_\_\_\_\_ heat intolerance

**PSYCHIATRIC:**

- \_\_\_\_\_ depression
- \_\_\_\_\_ schizophrenia
- \_\_\_\_\_ nervousness
- \_\_\_\_\_ shakiness
- \_\_\_\_\_ other psychiatric illnesses

**ENDOCRINE:**

- \_\_\_\_\_ diabetes
- \_\_\_\_\_ heat intolerance
- \_\_\_\_\_ excessive thirst
- \_\_\_\_\_ thyroid disease

**HEMATOLOGICAL:**

- \_\_\_\_\_ bleeding disorder
- \_\_\_\_\_ easy bruising
- \_\_\_\_\_ sickle cell anemia

**IMMUNE:**  
\_\_\_\_\_ HIV

**WOMEN:**

Age at first menstrual period: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Recent changes? **Y / N**

Post-menopausal? **Y / N**

# of pregnancies: \_\_\_\_\_ # vaginal deliveries \_\_\_\_\_ # C-sections: \_\_\_\_\_ # miscarriages: \_\_\_\_\_

Is there any chance you could be pregnant now? **Y / N**