

SUFFOLK SURGICAL GROUP, P.C.

*General Surgery
Breast Surgery*

*Bariatric Surgery
Vascular/Ultrasound Lab*

*Laparoscopic Surgery
Pacemaker Clinic*

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MEDICAL HISTORY

NAME: _____ **DATE:** _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

OCCUPATION: _____

MARITAL STATUS: ___ MARRIED ___ DIVORCED ___ SINGLE ___ PARTNERSHIP

PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE: _____

WHAT BRINGS YOU TO OUR OFFICE TODAY? _____

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

HEADACHES	YES___ NO___	STRESS INCONTINENCE	YES___ NO___
SHORTNESS OF BREATH	YES___ NO___	INDIGESTION/HEARTBURN	YES___ NO___
COUGH	YES___ NO___	VOMITING	YES___ NO___
PALPITATIONS	YES___ NO___	ABDOMINAL PAIN	YES___ NO___
CHEST PAIN	YES___ NO___	BLOOD IN URINE/STOOL	YES___ NO___
DIZZINESS	YES___ NO___	DIFFICULTY URINATING	YES___ NO___
FATIGUE	YES___ NO___	PAIN/SWELLING IN LEGS	YES___ NO___
CONSTIPATION	YES___ NO___	VARICOSE VEINS	YES___ NO___
JOINT/MUSCLE PAINS	YES___ NO___	DEPRESSION	YES___ NO___
ANXIETY	YES___ NO___	INSOMNIA	YES___ NO___
SNORING	YES___ NO___	EXCESSIVE DAYTIME SLEEPINESS	YES___ NO___
IMPOTENCE	YES___ NO___	FALL ASLEEP INAPPROPRIATELY	YES___ NO___

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING ILLNESSES/DISEASES?

HEART DISEASE	YES___ NO___	DIABETES	YES___ NO___
HIGH BLOOD PRESSURE	YES___ NO___	HEART ATTACK	YES___ NO___
STROKE	YES___ NO___	HIGH CHOLESTEROL	YES___ NO___
ASTHMA	YES___ NO___	EMPHYSEMA/COPD	YES___ NO___
DEPRESSION	YES___ NO___	CONGESTIVE HEART FAILURE	YES___ NO___
ARTHRITIS	YES___ NO___	CANCER	YES___ NO___
KIDNEY DISEASE	YES___ NO___	GLAUCOMA/ EYE PROBLEMS	YES___ NO___
SLEEP APNEA	YES___ NO___	GALLBLADDER DISEASE	YES___ NO___

GASTRO ESOPHAGEAL REFLUX DISEASE (GERD)	YES___ NO___		
POLY CYSTIC OVARIAN SYNDROME (PCOS)	YES___ NO___		
LUPUS/OTHER COLLAGEN DISEASE	YES___ NO___		
ULCER/GASTROINTESTINAL DISEASE	YES___ NO___		
THYROID DISEASE	YES___ NO___	HYPER OR HYPO (PLEASE CIRCLE ONE)	

SOCIAL HISTORY:

DO YOU CURRENTLY SMOKE CIGARETTES? YES___NO___ #OF CIGARETTES/DAY

IF NO, HAVE YOU EVER SMOKED CIGARETTES IN THE PAST?

YES___NO___ # OF CIGARETTES/DAY DATE QUIT_____

DO YOU DRINK ALCOHOL? ___NO ___SOCIAL ___OCCASIONAL ___DAILY

DO YOU HAVE ANY HISTORY OF DRUG OR ALCOHOL ABUSE? YES___NO___

IF YES, PLEASE LIST: _____

FOR OUR FEMALE PATIENTS:

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____

ARE YOUR MENSTRUAL PERIODS REGULAR? YES___ NO___ AGE OF MENOPAUSE _____

DATE OF LAST PAP _____ DATE OF LAST MAMMOGRAPHY _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? NO YES IF YES, PLEASE LIST OR PROVIDE LIST:

MEDICATION	DAILY DOSE	FREQUENCY

* PLEASE INFORM RECEPTIONIST IF ADDITIONAL SPACE IS NEEDED

ARE YOU ALLERGIC TO ANY MEDICATIONS/FOOD? NO YES IF YES, PLEASE LIST:

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS OR SURGERY? IF YES, PLEASE LIST BEGINNING WITH THE MOST RECENT:

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
BROTHER(S)	_____	_____	_____	_____
SISTER(S)	_____	_____	_____	_____

DO ANY OF YOUR BLOOD RELATIVES HAVE / HAD:

	NO	YES	IF YES, WHO?
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____
BREAST MASSES OR BREAST TUMORS	<input type="checkbox"/>	<input type="checkbox"/>	_____

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? NO YES