Oakland GENERAL SURGERY

Medical Information Form

Name_____ **Date**_____

Name preferred to be called:_____

List of Doctors:_____

Reason for Visit:_____

Past Medical History: (check all that apply): # Pregnancies_____ # Deliveries_____

- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Tuberculosis
- ☐ Reflux
- ☐ Diabetes Mellitus
- ☐ Insulin Use
- ☐ Pacemaker
- ☐ Lung Disease
- ☐ Asthma
- ☐ Seizures
- ☐ Peripheral Vascular Disease
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Ulcers
- ☐ Stroke
- ☐ Irregular Heart Beat
- ☐ Congestive Heart Failure
- ☐ Hepatitis
- ☐ Thyroid
- ☐ Other:_____

Past Surgery(s):_____

Medications (Doses):_____

Drug Allergies:_____ **Latex Allergy**_____

Alcohol: Yes☐ No☐ Type/Quantity_____ Frequency_____

Smoking Status: Please fill in blanks with when you started, how much, and/or when you quit.

- ☐ Every day:_____
- ☐ Former:_____
- ☐ Some day:_____
- ☐ Never
- ☐ Status unknown
- ☐ Unknown if ever smoked

Drug Use: Yes☐ No☐ Type/Quantity_____ Past Use_____

Height:_____ **Weight:**_____

Family History: If any apply, please state the relationship of the family member.

- ☐ Heart Disease_____
- ☐ Bleeding Disorders_____
- ☐ Diabetes_____
- ☐ Cancer/Type_____
- ☐ Other:_____
- ☐ None_____

System Review:

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Fevers/Chills
- ☐ Dizziness
- ☐ Fatigue/Weakness
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Visual Disturbance
- ☐ Hearing Problems
- ☐ Weakness in Extremities
- ☐ Chest Pain
- ☐ Altered Bowel Habits
- ☐ Altered Bladder Habits
- ☐ Poor Appetite/Weight Loss
- ☐ Other

Other medical information you wish to provide_____