Springfield Ambulatory Surgery Center
New Patient – Medical History

Name:________________________________ **DOB:**__________ **Age:**_____ **Today's Date:** _________

Occupation:____________________________________ **Marital Status:**_________________________

Reason for Visit:____

Family History (include relation if applicable):

Colon Cancer:________________ Colon polyps:_________________

Ulcerative Colitis or Crohn's Disease: ________________ Liver Disease:__________________

Medications/Dose/Frequency (include over-the-counter drugs):

____

____

____

Allergies to medications, latex or IV dye:____________________________________

Any previous reactions to anesthesia:_______________________________________

Blood Thinner Treatment: Coumadin/Warfarin Plavix Aspirin

Do you smoke? Yes No # of packs per day:____ / # of years smoke:____ / Quit?:_______

Do you use alcohol? Yes No # of drinks per week:____

History of excessive alcohol use:____

History of drug/substance abuse:____

Prior Surgical History (list all operations):

____

____

Heart Attack	Angina	Pacemaker	Coronary Blockages
Congestive Heart Failure	Irregular Heart Rhythm	Artificial Valve	Heart Valve problems
Stent or Angioplasty	Bypass	Defibrillator	Bleeding Problems
Diabetes	High Blood Pressure	Stroke/TIA	Asthma
COPD/Emphysema	Sleep Apnea	Home Oxygen	Kidney disease
Kidney dialysis	Thyroid disease	Lupus	Sarcoid
HIV	Hepatitis B or C	Pancreatitis	Anemia
Anxiety/Depression	Bipolar disorder	Rheumatoid arthritis	

Prior blood transfusion History of Cancer:____

Which of the following are you experiencing? Please check either 'Yes' or 'No'

Constitutional

Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Eyes

Blurred vision	No	Yes
Glaucoma	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss	No	Yes
Ringing in the ears	No	Yes
Mouth sores	No	Yes

Cardiovascular

Chest pain	No	Yes
Shortness of breath	No	Yes
Swelling of the ankles	No	Yes

Respiratory

Chronic cough	No	Yes
Spitting up blood	No	Yes
Wheezing	No	Yes

Genitourinary

Burning when urinating	No	Yes
Blood in urine	No	Yes

Musculoskeletal

Joint pain or swelling	No	Yes
Back pain	No	Yes
Muscle pain	No	Yes

Skin

Rash	No	Yes
Itching	No	Yes

Gastrointestinal

Poor appetite	No	Yes
Swallowing difficulty	No	Yes
Heartburn	No	Yes
Nausea/Vomiting	No	Yes
Bloating	No	Yes
Belching	No	Yes
Regurgitation	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal pain	No	Yes
Recent change in bowel habits	No	Yes
Rectal bleeding	No	Yes
Black, tarry stools	No	Yes
Blood in stools	No	Yes

Neurological

Headaches	No	Yes
Seizures	No	Yes
Strokes	No	Yes
Numbness	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Depression/Anxiety	No	Yes

Endocrine

Heat or cold intolerance	No	Yes
Excessive thirst	No	Yes
Excessive urination	No	Yes

Hematological

Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Blood transfusion	No	Yes

Are you pregnant? No Yes

How did you hear about us?____

Patient's Signature:____

Comments/Notes:

Reviewed:

______________________________ Date:__________ By:____________________
______________________________ Date:__________ By:____________________