

Medical History

Palmetto Health USC

MEDICAL GROUP

WEIGHT MANAGEMENT CENTER

Please fill out the entire form. One of our staff can help you with any questions you may have about the form. The information that you provide will be helpful to your surgeon in making decisions concerning your health. Some questions are repetitive but please answer all questions and fill in all blanks. Your doctor or nurse may ask you to give more detail (orally) about certain "positive" answers.

Patient Info

Patient _____ Date _____ Age _____ DOB _____

Name of doctor who referred you to this office _____

Name of regular physician _____ Name of cardiologist, if any _____

Name of dialysis center _____ Days you go _____

Brief description of problem for which you were referred _____

Please list all medications and supplements including dosages and number of doses taken daily (May attach separate paper)

List any drug and food allergies (including latex and tape)

Check below, for each item that may pertain to you:

- Y N Heart Surgery Y N Pacemaker Y N Defibrillator Y N Hysterectomy
- Y N Gallbladder Surgery Y N Appendix Surgery Y N Hernia Surgery Y N Cancer

List all other prior surgical operations and appropriate dates (May exclude minor orthopedic, dental and skin operations)

List prior major illnesses and Injuries including approximate dates (Please be brief)

Social History (Circle One)

Marital status: Single Married Divorced Widowed

Names of individuals living with you _____

Occupation _____

Smoker? Y N Packs per day _____ If not a smoker, did you previously smoke? Y N Quit date _____

Alcohol use (circle one): Never Occasional Moderate Heavy

Are you disabled? Y N If yes, what is the disability? _____

Office Use Only:

BP _____ Height _____ Weight _____

Pulse _____ Temp _____ Respiration _____

Name _____ Chart # _____

Reveiwed by _____, MD Date _____

Reviewed by _____, MD Date _____

Family History

List the predominant health problems affecting the following relatives.
(Consider cancer, hypertension, diabetes, morbid obesity, heart attack, stroke, and kidney failure). Be brief.

Father _____

Mother _____

Brother(s) _____ Sister(s) _____

Review of Systems

Check the symptoms and/or diagnoses that apply to you. You may write in symptoms and diagnoses, as well.

Y N **General Symptoms:** recent fever, unintended weight loss, fibromyalgia, chronic fatigue _____

Y N **Immunologic/Allergies:** HIV/AIDS, lupus, sarcoidosis _____

Y N **Hematologic/Lymphatic:** anemia, leukemia, lymph node enlargement, lymphedema, deep venous thrombosis, phlebitis pulmonary embolus (blood clots in lungs), easy bruising _____

Y N **Endocrine/Glands:** diabetes, thyroid problems, adrenal problems _____

Y N **Psychiatric:** major depression, minor depression, psychosis, anxiety disorder, bipolar illness _____

Y N **Heart and Blood Vessels:** prior heart attack, angina, chest pains, heart valve problems, aneurysms, artery occlusions or narrowings, vein problems, irregular heartbeat, high cholesterol, high blood pressure _____

Y N **Respiratory:** COPD, emphysema, asthma, sleep apnea, persistent cough, persistent hoarseness, Tuberculosis _____

Y N **Gastrointestinal:** diverticulosis, diverticulitis, constipation, diarrhea, irritable bowel syndrome, colitis, gastroesophageal reflux disease, peptic ulcer disease, gallbladder problems, liver problems (cirrhosis, hepatitis, other), intestinal obstruction, nausea, vomiting _____

Y N **Genitourinary:** kidney failure, kidney stones, kidney transplant, prostate problems, ongoing gynecological problems _____

Y N **Musculoskeletal:** arthritis (severe, not severe), deformities, braces, walking aids, muscle abnormalities _____

Y N **Skin:** recurrent infections, psoriasis, other _____

Y N **Are you currently being treated for MRSA (Methicillin Resistant Staphylococcus Aureus)?** _____

If no, have you been treated for MRSA in the past? Y N _____

Y N **Breasts:** prior cancer, prior biopsies, current mass, current pain _____

Y N **Neurological:** stroke, headache problems, neuropathy, poor balance, seizures _____

Y N **Eyes:** nearsighted, glasses, contacts, partial or total blindness, glaucoma _____

Y N **Ears, Nose, Mouth, Throat:** pain, deafness, hoarseness, frequent nosebleeds _____

Y N **Do you have diabetes?** _____

Y N **Do you take any blood thinners such as Coumadin, Heparin, or Plavix?** _____

Y N **Do you have mitral valve prolapsed?** _____

Y N **Are you being treated for hypertension?** _____