NAME:	Date Of Birth:	Date:

CHIEF COMPLAINT

1. For what problem are you seeing the doctor today?

HISTORY OF PRESENT ILLNESS

When did your problem, injury or pain begin?

Is this a work-related injury or illness? ☐ **YES** ☐ **NO**

If yes, You MUST provide workers compensation information to Santa Fe Surgical Associates.

Were you seen in the Emergency Room?	Yes ☐	No ☐	Date:

How did your problem start? (Please check all that apply.)	Suddenly ☐	During sports ☐	Fall ☐	Lifting ☐	Auto Accident ☐	No apparent cause ☐
	Over time ☐	At work ☐	Twisting ☐	Pulling ☐		
	Other (describe):					
What are your symptoms? (Please check all that apply.)	Pain ☐	Swelling ☐	Redness ☐	Bruising ☐	Spasm ☐	Weakness ☐
	Tingling ☐	Bleeding ☐				
If you have pain, how would you describe it? (Please check all that apply.)	Constant ☐	Intermittent ☐	While at rest ☐	At night ☐		
	With Activity ☐	Burning ☐	Aching ☐	Sharp ☐	Dull ☐	

On average, how severe is your pain? Circle One	1	2	3	4	5	6	7	8	9	10
	No Pain									Worst Pain Imaginable

Have you had any diagnostic tests for this problem? (Please check all that apply.)

☐ X-Ray ☐ CT Scan ☐ Ultrasound ☐ Biopsy

☐ Mammogram ☐ Nuclear Med/Hida Scan

Where were studies done & what date?

Location: Date:

Have you or your family ever had any of the following conditions? *(Please check all that apply.)*

Please check the 'S' box if you have any of the conditions. Please note the following: F = Father M = Mother SIB = Brother/Sister

Condition					Condition					Condition				
Abnormal Mammograms	S	F	M	SIB	Kidney disease/failure	S	F	M	SIB	HIV	S	F	M	SIB
Thyroid problems	S	F	M	SIB	Diabetes	S	F	M	SIB	TB	S	F	M	SIB
Asthma or emphysema	S	F	M	SIB	Bone or joint problems	S	F	M	SIB	Hepatitis	S	F	M	SIB
High blood pressure	S	F	M	SIB	Arthritis or rheumatism	S	F	M	SIB	Depression	S	F	M	SIB
Heart Problems	S	F	M	SIB	Gout	S	F	M	SIB	Weight Loss	S	F	M	SIB
Bleeding problems	S	F	M	SIB	Osteoporosis	S	F	M	SIB	Balance problems	S	F	M	SIB
Blood Clots	S	F	M	SIB	Cancer	S	F	M	SIB	Other				
Stomach Problems/ulcers/reflux	S	F	M	SIB	Skin Disorders	S	F	M	SIB					
Bowel or bladder problems	S	F	M	SIB	Stroke	S	F	M	SIB					

Are you allergic to any medications? ☐ YES ☐ NO

Are you allergic to Latex? ☐ YES ☐ NO

Please list medications causing allergic reactions: If needed, ask for additional paperwork.

Women Only: Are you, or could you be, pregnant? ☐ YES ☐ NO	Due Date?	Last menstrual period?

Are you on ***Dialysis***? If Yes which days? (Circle all that apply) ☐ YES ☐ NO Mon Tues Wed Thur Fri	Location of Dialysis?

PLEASE FILL OUT REVERSE SIDE OF FORM →

REVIEW OF SYSTEMS: Are you currently experience any of the following? ***Please circle all that apply.***							
General	Weight change	Fatigue	Fever	Chills	Nights Sweats		
Skin	Itching	Rashes	Sores	Lumps			
HEENT	Headaches	Visual changes	Hearing Loss	Dizziness	Earaches	Allergy	Sore Throat
Respiratory	Shortness of Breath	Cough	Asthma				
Cardiac	High Blood Pressure	Chest Pain/Pressure	Irregular Heart Beat				
GI	Nausea	Vomiting	Constipation	Abdominal Pain			
Urinary	Burning/Pain Urinating	Kidney Stones	Urinary Tact Infection	Frequency of Urination			
Vascular	Swelling in the Legs	History of Blood Clots	Varicose Veins				
Musculoskeletal	Muscle Weakness	Pain	Joint Stiffness	Instability	Redness/Swelling	Arthritis	Gout
Neurologic	Fainting	Numbness	Tingling	Tremors	Weakness/Paralysis		
Hematologic	Easy Bruising	Bleeding Problems	Anemia				
Endocrine:	Heat/Cold Intolerance	Excessive Sweating	Thyroid Problems	Diabetes			
Psychiatric	Anxiety	Depression	Bipolar	Suicide Attempts	Other Psychological Diagnosis		

PAST MEDICAL HISTORY

Please list ALL previous major surgeries:		**Have you had Anesthesia?** *(List complications if any)*
Surgery:	Date:	YES NO
Surgery:	Date:	
Surgery:	Date:	**Have you had a blood transfusion?** *(List complications if any)*
Surgery:	Date:	YES NO

SOCIAL HISTORY

What is/was your occupation? | Employer:

Do/did you use tobacco? Yes No | Type of tobacco? | How much? | Quit when?

Do you drink alcoholic beverages? Yes No | How many? __________ per day /week / month / year (circle one)

Do you use "street" drugs? Yes No | Which?

Have you ever been addicted to prescription or non-prescription drugs? Yes No | Which?

Do you live alone? Yes No | How often do you exercise? Circle One: Never Daily Monthly Rarely Weekly

What type of exercise?

MISCELLANIOUS

Were you referred here by a physician? Yes No | Physician Name:

Who is your primary care physician? | Is there any legal action pending that pertains to your visit?

Religious/Personal/Cultural Beliefs:
Are you able to receive blood products: Yes___________________ No__________________ Explain:

Will you participate in surgical procedures: Yes__________________ No_________________ Explain:

Interpreter Required? Yes____________________ No______________________ Language: ______________________

Do you wish to be listed as a ***Do Not Resuscitate*** patient? Yes________________________ No _____________________

Abuse:
Has there been any history of abuse within the household: Yes___________________ No___________________ If yes Explain:
(Do you feel safe at home?)

Reviewed by: ____ **Date reviewed:** ___________________________________