

**EAST ORLANDO GENERAL SURGERY  
HISTORY AND PHYSICAL**

PATIENT NAME: \_\_\_\_\_

Date of Birth: ___/___/___	Sex:     M     F	Today's Date: ___/___/___
Name:		Occupation:
With whom do you live?		Relationship?
Name of referring physician?		Marital Status?    S    M    W    D

Explain in your own words the present problem you wish to have evaluated:

List known Drug Allergies	List Current Medications	List Current Medications	Are you currently taking:
1.	1.	6.	Aspirin                    Yes No
2.	2.	7.	Birth Control Pills    Yes No
3.	3.	8.	Coumadin                Yes No
4.	4.	9.	<b>Estrogen</b> Yes No
5.	5.	10.	Plavix                    Yes No

**PAST MEDICAL HISTORY**

Medical	Medical	Endoscopic Procedures	Females Only Section
AIDS /HIV            Yes No	High Blood Pressure Yes No	Please give dates for those marked "yes"	Please give dates for following
Anemia                Yes No	High Cholesterol    Yes No	Colonoscopy            Yes No	First menstrual period?
Anxiety                Yes No	Kidney Disease      Yes No		Last menstrual period?
Arthritis              Yes No	Kidney Stones        Yes No	Upper Endoscopy Yes No	Currently pregnant?    Yes No
Asthma                Yes No	Liver Disease        Yes No		First Pregnancy
Breast Discharge    Yes No	Measles                Yes No	Have you ever had a blood transfusion?            Yes No	# of pregnancies? 1 2 3 4 5+
Bronchitis            Yes No	Menstrual Problems Yes No		Last pap smear?
Cancer                Yes No	Migraine Headaches Yes No		Breast Biopsy?            Yes No
Cataracts             Yes No	Pneumonia            Yes No		
Chest Pain            Yes No	Prostate Problems    Yes No	<b>SOCIAL HISTORY</b>	
Depression            Yes No	Rectal Bleeding      Yes No	Do you smoke?            Yes No	
Diabetes                Yes No	Rheumatic Fever     Yes No	# of packs per day        # of years	
Endocarditis         Yes No	Sexual Dysfunction    Yes No	Do you consume alcohol? Yes No	
Emphysema            Yes No	Stomach Ulcers        Yes No	Use recreational drugs? Yes No	
Glaucoma             Yes No	Stroke                 Yes No		
Gout                    Yes No	Swallowing Problems Yes No		
Heart Burn            Yes No	Thyroid Problems    Yes No		
Heart Trouble         Yes No	Venous Thrombosis    Yes No		
Hepatitis             Yes No			

**Surgeries**

Physician Notes Section:

Please give dates for those marked "yes"

Cardiac Bypass	Yes No	Date: ___/___/___
Endarterectomy	Yes No	Date: ___/___/___
Heart Valve	Yes No	Date: ___/___/___
Pacemaker	Yes No	Date: ___/___/___
Appendectomy	Yes No	Date: ___/___/___
Gallbladder	Yes No	Date: ___/___/___
Hernia Repair	Yes No	Date: ___/___/___
C-Section	Yes No	Date: ___/___/___
Hysterectomy	Yes No	Date: ___/___/___
Other	Yes No	Date: ___/___/___
Other	Yes No	Date: ___/___/___

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY HISTORY**

<b>Check All Applicable Boxes</b>	<b>Father</b>	<b>Mother</b>	<b>Father's Parents</b>	<b>Mother's Parents</b>	<b>Siblings</b>	<b>Children</b>
Bleeding Disorders						
Cancer - Breast						
Cancer - Colon						
Diabetes						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Stroke						
Thyroid Disease						
Other						