

Surgical Associates of Austin, P.A.

Cherico • Markus • Mayer • Ashworth • Ching • Sankar • Esquivel

History and Physical Form (Please print neatly)

Chart # _____

Please complete numbers 1 through 16 prior to returning form to receptionist. Thank you.

Date: _____

1. Patient Name: _____ Age: _____ Sex: M F
Last First Middle

2. Chief Complaint (nurse to complete): _____

3. Other Physicians involved in your care: Primary Care: _____
Specialists: _____

4. Drug Allergies: None Yes **If Yes, List drugs:** _____

5. Medications: None See attached list if more than four (include aspirin, Motrin, etc.) _____

6. Other Medical Problems: None
 Congestive Heart Failure High Blood Pressure Diabetes Heart Murmur
 Prior Heart Attack History of Stroke Emphysema Cancer (Type) _____
 Mitral Valve Prolapse High Cholesterol / Lipids Bronchitis Arthritis
 Heart Rhythm Problem Clots in Leg Veins Asthma Seizures
 Other: _____

(Doctor's Notes): _____

7. Previous Operations (with last two digits of approximate year) None
 Heart Valve _____ Groin Hernia _____ C-Section(s) _____ Arthroscopy _____
 Total Joint _____ Other Hernia _____ Breast Biopsy(ies) _____ Spine Surgery _____
 Gallbladder _____ Colon Surgery _____ Mastectomy _____ Thyroid _____
 Appendectomy _____ Hysterectomy _____ Coronary Artery Bypass _____ Cataract _____
 Other: _____

(Doctor's Notes): _____

8. If female, date of last normal menstrual period: _____ **9. Are you Postmenopausal?** Yes No

10. Alcohol: None Frequency: _____ **11. Tobacco:** None Frequency: _____ **12. History of IV Drug Use:** None Frequency: _____

13. Other Current Problems: None
 Chest Pain (Heart) Cough Significant Weight Loss Bleeding Tendency
 Irregular Heart Beat Coughed Up Blood Change in Bowel Habits Slurred Speech
 Shortness of Breath with Exertion Wheezing Blood in Stool Recently Urinary Problems
 Shortness of Breath at Night Constipation Diarrhea Weakness (Arms / Legs)
 Other: _____

(Doctor's Notes): _____

14. Names and ages of children: _____

15. Family History of: None Adopted
 Breast Cancer Ovarian Cancer Lung Cancer Colon Cancer Prostate Cancer Thyroid Cancer
 Melanoma Skin Cancer Throat Cancer Cervix Cancer Lymphoma Leukemia
 Multiple Myeloma Other Cancer: _____
 Early Age Heart Attack High Blood Pressure Diabetes Hemophilia or significant bleeding history
 Strokes Clots in the leg veins Gallbladder Disease

16. I will absolutely refuse blood transfusions under any circumstances: Yes No
 Other: _____