BAYOU SURGICAL SPECIALISTS, LLC

Past Medical Record

NAME: _____ BIRTHDATE: _____

DATE: _____ AGE: _____ FAMILY DOCTORS _____

Do you Smoke? ☐ Yes ☐ No ☐ Past Smoker _____

How many years did you smoke? _____

ALLERGIES:

Are you allergic to any of the following:

- ☐ Penicillin
- ☐ Sulfa
- ☐ IVP Dye
- ☐ Latex allergy
- ☐ None of the above

Others _____

_____

_____

PREVIOUS MEDICAL ILLNESSES:

Have you had any of the following:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Sinus problems
- ☐ Emphysema
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Increased blood pressure
- ☐ Mitral Valve Prolapse
- ☐ Heart attack or heart condition
- ☐ Diverticulosis
- ☐ Ulcer disease
- ☐ Hiatal Hernia
- ☐ Hemorrhoids
- ☐ Colon Polyps
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Gastritis
- ☐ Stroke
- ☐ Thyroid condition
- ☐ Cancer
- ☐ Breast Condition
- ☐ Prostate
- ☐ Kidney Stone
- ☐ Urinary Infection
- ☐ Arthritis
- ☐ Back Pain
- ☐ Gout
- ☐ Broken Bones _____
- ☐ **Acid Reflux** _____

Other medical conditions _____

_____ _____

_____ _____

_____ _____

PRESENT MEDICATION:

- ☐ ASA _____
- ☐ Coumadin _____
- ☐ Diabetic _____
- ☐ Hormones _____

OTHER MEDICATIONS:

_____

_____

_____

_____

PAST SURGERY:

- ☐ Eyes
- ☐ Tonsils/Adenoids
- ☐ Gall Bladder
- ☐ Appendix
- ☐ Hernia
- ☐ Breast Biopsy
- ☐ Hemorrhoidectomy
- ☐ Hysterectomy
- ☐ Angioplasty
- ☐ Heart Bypass
- ☐ Ovaries Removed
- ☐ Pacemaker

Other Surgeries:

_____

_____

_____

SYSTEM REVIEW:

Please check any symptoms present

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Dizziness
- ☐ Decreased vision
- ☐ Hoarseness
- ☐ Frequent headaches
- ☐ None of the above
- ☐ Glasses
- ☐ Contacts

CARDIOVASCULAR & RESPIRATORY:

- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Cough
- ☐ Night sweats
- ☐ Blood Sputum
- ☐ Irregular heart beat
- ☐ None of the above

GASTROINTESTINAL:

- ☐ Hernia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool/tarry stools
- ☐ Colon Polyps
- ☐ Hemorrhoids
- ☐ Nausea and/or vomiting
- ☐ Abdominal pain
- ☐ None of the above

MENSTRUAL HISTORY:

- ☐ Regular period
- ☐ Menopause
- ☐ Bleeding between periods
- ☐ Irregular periods

OB HISTORY:

- ☐ C-Section
- ☐ Natural Birth
- ☐ Miscarriage
- ☐ D & C
- ☐ Tubal Ligation
- ☐ Hysterectomy

FAMILY HISTORY:

Which of your family had any of the following diseases or conditions?

- ☐ Heart Condition _____
- ☐ Diabetes _____
- ☐ Cancer _____
  (What Kind Of Cancer)
- ☐ Tuberculosis _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Kidney Stones _____
- ☐ None of the above _____
- ☐ Other _____

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