Today's Date: _____

SURGICAL SPECIALISTS OF NORTHERN VIRGINIA

Surgery Evaluation Form: Please fill out completely & print clearly.

A. NAME_____ **AGE**_____ **BIRTH DATE**_____
First Middle Last

EMAIL ADDRESS: _____

PREFERRED PHARMACY NAME, ADDRESS AND PHONE NUMBER:_____
_____

B. **CHIEF COMPLAINT:** What brings you here today?_____

When did it start?_____

C. WHO REFERRED YOU TO OUR PRACTICE:_____

WHO IS YOUR PRIMARY CARE PHYSICIAN:_____

D. **PAST MEDICAL-SURGICAL HISTORY: (**List all health problems, surgeries, medication)

1. **MEDICAL PROBLEMS:**_____
_____
_____

2. **SURGERIES:**_____
_____
_____

3. **MEDICATIONS: (**Dosage and how often taken)
_____
_____
_____
_____
_____

4. **ALLERGIES TO MEDICATION: (List medication and type of reaction)—*to include Iodine and Shellfish***
_____
_____

5. **SMOKER, ALCOHOL, DRUGS: (Describe type, amount per DAY, years of use)**
Tobacco Use
__ Never Smoked
__Former Smoker _____
__Current Every Day Smoker_____
__Smoker Current Status Unknown_____
__Current Smokeless Tobacco User_____
__Unknown If Ever Smoked
__Exposure Secondhand Smoke _____

Alcohol_____ **Drugs**_____

6. **FAMILY HISTORY: (All medical problems, surgeries, cancer and cause of death)**
A: FATHER:_____
B. MOTHER:_____
C. SISTERS:_____
D. BROTHERS:_____
E. GRANDPARENTS:_____

FULL NAME_____ **TODAY'S DATE**_____

7. SOCIAL HISTORY:

A. Who is at home with you?_____

B. Your Occupation:_____

C. Student: (Grade & Location)_____

REVIEW OF SYSTEMS: (Please check YES or NO if you have had any of these conditions, symptoms or testing within the past 3-6 months.

1. Fever---------- **Y N**
2. Weight Loss---------- **Y N**
3. Shortness of breath---------- **Y N**
4. Night sweats---------- **Y N**
5. Loss of appetite---------- **Y N**
6. Productive cough---------- **Y N**
7. TB exposure---------- **Y N**
8. TB skin testing---------- **Y N**
9. Treated for TB---------- **Y N**
10. HIV screening---------- **Y N**
11. Upper respiratory infection------- **Y N**
12. Sore Throat---------- **Y N**
13. Sinus trouble---------- **Y N**
14. Swollen glands---------- **Y N**
15. Asthma---------- **Y N**
16. Sleep Apnea---------- **Y N**
17. Bronchitis/pneumonia---------- **Y N**
18. Migraines---------- **Y N**
19. Eye problems---------- **Y N**
20. Seizures---------- **Y N**
21. Stroke/TIA---------- **Y N**
22. Heart murmur----------**Y N**
23. Hypertension, high blood pressure Y N
24. Chest pain, angina---------- **Y N**
25. Heart palpitations, irregular heart rate---------- **Y N**
26. Stress test---------- **Y N**
27. EKG---------- **Y N**
28. Syncope/black out spell---------- **Y N**
29. Myocardial Infarction, Heart attack---------- **Y N**
30. Congestive heart failure---------- **Y N**
31. Blood clots in legs---------- **Y N**
32. Hepatitis or Jaundice (circle which one)------ **Y N**
33. Hepatitis vaccine---------- **Y N**
34. Upper abdominal pain---------- **Y N**
35. Lower abdominal pain---------- **Y N**
36. Rectal bleeding---------- **Y N**
37. Hemorrhoids---------- **Y N**
38. Rectal pain---------- **Y N**
39. Nausea---------- **Y N**
40. Vomiting---------- **Y N**
41. Vomiting blood---------- **Y N**
42. Diabetes/blood sugar---------- **Y N**
43. Thyroid disease---------- **Y N**
Hypothyroid---------- **Y N**
Hyperthyroid---------- **Y N**
44. Urinary tract infections---------- **Y N**
45. Kidney Dialysis---------- **Y N**
46. Arthritis---------- **Y N**
47. Anemia---------- **Y N**
48. Sickle Cell Disease---------- **Y N**
49. Blood disorder---------- **Y N**
50. Treatment for emotional or psychiatric disorder---------- **Y N**
51. Fear/phobia---------- **Y N**
52. Skin rashes---------- **Y N**
53. Skin disease---------- **Y N**
54. Colon polyps ---------- **Y N**
55. Ulcer disease---------- **Y N**
54. Difficulty swallowing ---------- **Y N**
55. Hiatal hernia/reflux ----------**Y N**
56. Heartburn/indigestion---------- **Y N**
57. Women Only
Are you pregnant? ---------- **Y N**
Date of late menstrual cycle_____

LIST OTHER:_____

FOR WOMEN WITH A BREAST CONDITION TO BE EVALUATED:

1. Prior History of Breast Problems, Surgery:_____

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2. Number of Pregnancies_____
3. Number Live Births_____**, Breast Fed**_____**or Bottle Fed**_____
4. Your Age when first child born_____
5. Your Age when menstrual periods began_____**, or when stopped**_____
6. Have you used Birth Control Pills----------**Y N Number ofYears**_____
7. Have you used Hormone Replacement Therapy---- **Y N Number of Years**_____
8. Have you used Fertility Drugs---------- **Y N When**_____
9. Do you perform Self Breast Exams---------- **Y N How often**_____