SURGICAL SPECIALISTS OF NORTHERN VIRGINIA

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

			Date:
First:	**Middle:**	**Last:**	
Birthdate:	**Age:**	**Height:**	**Weight:**

Who referred you to our practice? _____

Who is your primary care physician? _____

Reason for Visit: _____ **Duration:** _____

Preferred Pharmacy: (Name, City and Phone Number) _____

List other physicians you are seeing:

Physician Name	**Specialty**

Allergies (Medications, food, environmental)	**Reaction**

Medications: (List all current medications)

Date started	**Medication & Dose**	**Directions**	**Reason for Taking**	**Prescribed by**

_____C. Cross _____J. Lesniewski _____V. Madey _____B. Kriss _____ J. Cook

Past Medical History: (Please check any past medical history and/or list any past medical history under other)

☐ **Attention Deficit Disorder**	☐ **GI Dizziness/Vertigo**	☐ **High cholesterol**	☐ **Pneumonia**
☐ **Alcohol Disorder/Drug addiction**	☐ **Easy Bleeding**	☐ **Hiatal Hernia**	☐ **Psoriasis**
☐ **Anemia**	☐ **EKG (list year)** _____	☐ **HIV Infection**	☐ **Reflux**
☐ **Arrhythmia**	☐ **Emphysema**	☐ **Hodgkin's Disease**	☐ **Rheumatoid Arthritis**
☐ **Arthritis**	☐ **Epilepsy**	☐ **Insomnia**	☐ **Seizure Disorder**
☐ **Asthma**	☐ **Esophageal Reflux**	☐ **Kidney Dialysis**	☐ **Sickle Cell Disease**
☐ **Artificial joints**	☐ **Fatigue**	☐ **Kidney poor function**	☐ **Skin Disease**
☐ **Back Problems**	☐ **Fibromyalgia**	☐ **Kidney stones**	☐ **Sleep Apnea**
☐ **Blood clots in legs**	☐ **Gallstones**	☐ **Leukemia**	☐ **STDs**
☐ **Bronchitis**	☐ **Gastrointestinal Disorder**	☐ **Lung disease**	☐ **Stomach Ulcers**
☐ **Cancer (list type)** _____	☐ **Glaucoma**	☐ **Lupus**	☐ **Stroke Syndrome**
☐ **Colon polyps**	☐ **Gout**	☐ **Lyme Disease**	☐ **Thyroid Disorders**
☐ **Concussion**	☐ **Headache**	☐ **Melanoma**	☐ **Tuberculosis**
☐ **Congestive Heart Failure**	☐ **Heart Attack**	☐ **Migraine or** ☐ **Headache**	☐ **Ulcer disease**
☐ **COPD**	☐ **Hemorrhoids**	☐ **Osteoporosis**	☐ **Urinary tract infections**
☐ **Depression**	☐ **Hepatitis or** ☐ **Jaundice**	☐ **Pancreatitis**	☐ **Diabetes Mellitus**
☐ **High Blood Pressure**	☐ **Other (List)** _____		

Please list any surgeries: (Please write year of surgery and type)

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Tuberculosis Symptom Screening: (Please check Yes or No)

Have you had contact with anyone with active tuberculosis disease in the past year? ☐ Yes ☐ No	
Have you had a TB Skin Test? ☐ Yes ☐ No	**Have you ever been treated for TB? ☐ Yes ☐ No**

Family History: (All medical problems, surgeries, cancer and cause of death)

	Medical Problems	Surgeries	Cancer	Cause of death (age)
Mother:				
Father:				
Sisters:				
Brothers:				
Grandparents:				

Other: (Please list any significant health issues with Aunts, Uncles, Cousins, and Children. Please specify who has the specific issue.)

_____

Social History: (Please write and/or check the appropriate answer)

Who lives with you?	
Occupation	
Do you currently smoke?	☐ **Yes** ☐ **No** ☐ **Former**
How much per day do you smoke?	_____ **Pack per day or** _____ **cigarettes per day**
What do you smoke? (i.e. cigars)	
Do you drink alcohol?	☐ **Yes** ☐ **No**
How often do you drink?	☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Social Drinker**
Do you currently use recreational drugs?	☐ **Yes** ☐ **No**
Have you ever used recreational drugs?	☐ **Yes** ☐ **No**
Please specify type and extent of use:	
Are you pregnant?	☐ **Yes** ☐ **No**
Date of Last Menstrual cycle?	

Review of Systems: (Please circle **ALL** symptoms within the past 3 months for each category below).

General/constitutional

☐ Fever ☐ Weight loss ☐ Change in appetite ☐ Headaches ☐ Night sweats ☐ Recent illness ☐ Sleep disturbance
☐ Weight gain ☐ Chills ☐ Fatigue

ENT

☐ Sore throat ☐ Nasal congestion ☐ Sinus trouble ☐ Dizziness ☐ Nosebleed ☐ Difficulty swallowing ☐ Eye problems ☐ Hearing loss

Cardiovascular

☐ Anemia ☐ Easy bruising ☐ Murmurs ☐ Blood clots ☐ Difficulty lying flat
☐ Edema ☐ Ankle swelling ☐ Swelling in Hands/Feet ☐ Chest Pain ☐ Heart Palpitations ☐ Shortness of Breath

Respiratory

☐ Breathing problems ☐ Cough ☐ Wheezing ☐ Coughing up Blood ☐ Shortness of Breath

Gastrointestinal

☐ Gas/bloating ☐ Acid reflux ☐ Hemorrhoids ☐ Diarrhea ☐ Indigestion
☐ Lower abdominal pain ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Vomiting blood
☐ Upper abdominal pain ☐ Stomach problems ☐ Rectal pain ☐ Rectal Bleeding

Genitourinary

☐ Urine leakage ☐ Kidney stones ☐ Large prostate ☐ Erectile dysfunction ☐ Heavy uterine bleeding ☐ Frequent urination ☐ Painful urination ☐ Difficulty urinating

Musculoskeletal

☐ Back pain ☐ Arthritis ☐ Neck problems ☐ Limb weakness ☐ Leg cramps
☐ Muscle aches ☐ Joint stiffness

Neurologic

☐ Seizures ☐ Tingling ☐ Numbness ☐ Loss of consciousness ☐ Loss of balance

Psychological

☐ Anxiety ☐ Depressed Mood ☐ Treatment for emotional or psychiatric disorder
☐Fear/phobia ☐ Auditory/visual hallucinations

Skin

☐ Hives ☐ Skin Rashes ☐ Skin Lesions

BREAST PATIENTS ONLY

For women with a breast condition to be evaluated:

# of pregnancies: _____ Live Births:_____
☐ Breast Fed or ☐ Bottle Fed
Age when first child born: _____
Age when menstrual period began: _____
Age when menstrual period stop: _____
Have you used birth control pills? ☐ Yes (Medication Name: _____) ☐ No
Number of Years _____
Have you used Hormone Replacement Therapy? ☐ Yes (Medication Name: _____) ☐ No
Number of Years _____
Have you used fertility drugs? ☐ Yes (Medication Name: _____) ☐ No
When? _____
Do you perform self breast exams? ☐ Yes ☐ No
How often? _____

Breast History:

Did you or your doctor feel any new mass(es) in your breast? ☐ Yes ☐ No ☐ Not Applicable
If yes, which breast is it in? ☐ Right ☐ Left ☐ Both
How long has it been there? _____
Do you have any nipple discharge? ☐ Yes ☐ No ☐ Not Applicable
If yes, which nipple is it from? ☐ Right ☐ Left ☐ Both
How long has it been going on? _____
What color is it? ☐ Clear ☐ Bloody ☐ Green ☐ Yellow ☐ Milky ☐ Brown ☐ Cheesy
Does it come out by itself or only when you squeeze your nipple?
☐ By itself ☐ When I squeeze
Do you have any breast pain? ☐ Yes ☐ No ☐ Not Applicable
If yes, which breast is it in? ☐ Right ☐ Left ☐ Not Applicable
Does it get worse around your periods? ☐ Yes ☐ No
When did it start? _____
Have you had any breast imaging since your last clinic visit? ☐ Yes ☐ No ☐ Not Applicable
If yes, what study did you have? _____
Where was it done? _____
If you underwent breast surgery, do you have any swelling, heaviness, tenderness, or decreased range of motion of your arm? ☐ Yes ☐ No ☐ Not Applicable