PARAGON SURGICAL SPECIALISTS **DATE**______________________

Name ____ Birth Date______________________
Male______ Female______ Primary Care Physician____
Height______ Weight______ Referring Doctor (if different from Primary) ________________________
Language Preference: English ____________________ Local Pharmacy______________________________
Advanced Directives / Living Will: Yes / No - Type______________
How would you like to be contacted for: Appointment Reminders: Phone __ Text Message ___ Email ___
Billing / Insurance Questions: Phone __ Text Message ___ Email ___
Race (Circle One): American Indian or Alaska Native; Asian; Black or African American; more than one race; Native Hawaiian; Other Pacific Islander; White
Ethnicity (Circle One): Hispanic / Latino
Not Hispanic / Latino

Medication	Dose	Frequency	Medication	Dose	Frequency

ALLERGIES:
Medication Allergies: None ____
Other: Adhesive Tape Yes No Betadine Yes No
Latex Yes No Shellfish Yes No

HISTORY OF PRESENT ILLNESS
Reason for Today's Visit:____

Is this a work-related injury? Yes / No

CURRENT COMPLAINTS:

General:
Fatigue Yes No
Fever Yes No
Weight Gain Greater than 10 lbs Yes No
Weight Loss Greater than 10 lbs Yes No
Skin:
Hair Loss Yes No
Rash Yes No
Skin Color Changes Yes No

HEENT:
Head Injury Yes No
Visual Loss Yes No
Hearing Loss Yes No
Hoarseness Yes No
Sore Throat Yes No
Neck:
Neck Mass Yes No
Swollen Glands Yes No
Respiratory:
Chronic Cough Yes No
Difficulty Breathing Yes No
Wheezing Yes No
Breast:
Breast Mass Yes No
Breast Pain Yes No
Breast Swelling Yes No
Nipple Discharge Yes No
Skin Changes On the Breast Yes No

Cardiovascular:
Chest Pain Yes No
Palpitation Yes No
Swelling of Extremities Yes No

Gastrointestinal:
Abdominal Pain Yes No
Bloody Stool Yes No
Constipation Yes No
Diarrhea Yes No
Difficulty Swallowing Yes No
Heartburn Yes No
Indigestion Yes No
Vomiting Yes No
Nausea Yes No
Genitourinary:
Male:
Blood in urine Yes No
Change in urinary stream Yes No
Incontinence Yes No
Painful Urination Yes No
Testicular mass Yes No
Testicular pain Yes No
Female:
Are you pregnant Yes No
Vaginal Bleeding Yes No
Painful Urination Yes No
Incontinence Yes No
Blood in Urine Yes No
Discharge Yes No
Musculoskeletal:
Back Pain Yes No
Joint Pain Yes No
Joint Stiffness Yes No
Joint Swelling Yes No
Muscle Weakness Yes No

Neurological:
Seizures Yes No
Stroke Yes No
Weakness in extremities Yes No
Psychiatric:
Anxiety Yes No
Depression Yes No
Panic Attacks Yes No
Endocrine:
Blurred Vision Yes No
Excessive Thirst Yes No
Thyroid Problems Yes No

Hematology:
Hoarseness Yes No
Blood Clots Yes No
Easy Bruising Yes No
Enlarged Lymph Nodes Yes No
Prolonged Bleeding Yes No

SOCIAL HISTORY:

Drug Use Yes No
Alcohol Use Yes No
Never Smoked Yes No
Smoker – amount _____

HEALTH MAINTENANCE:
Last Mammogram:
Date/Years ago _____
Last Colonoscopy:
Date/Years ago _____

PAST MEDICAL HISTORY:

Arthritis	Yes No
Asthma	Yes No
Bleeding Tendency	Yes No
If yes what type?______________	
Blood Clots If yes, Legs	Yes No
Lung	Yes No
Cancer:	Yes No
If yes what type?______________	
Radiation	Yes No
Chemotherapy	Yes No
COPD (Cardiopulmonary Disease)	Yes No
Diabetes	Yes No
Heart Attack	Yes No
Hepatitis	Yes No
High Blood Pressure	Yes No
High Cholesterol	Yes No
HIV/AIDS	Yes No
Kidney Failure	Yes No
If yes on Dialysis?	Yes No
Malignant Hyperthermia	Yes No
MRSA	Yes No
Seizure Disorder	Yes No
Stroke	Yes No

Hernia:	**R L**
Groin/Inguinal	Yes No
Hiatal	Yes No
Incisional	Yes No
Navel / Umbilical	Yes No
OB:	
C-section	Yes No
Tubal Ligation	Yes No
Orthopedic:	
Any Metal Rods/Plates	Yes No
Total Hip	Yes No
Total Knee	Yes No
Total Shoulder	Yes No
Thoracic:	
Esophageal Resection	Yes No
Lung Resection	Yes No
Vascular:	
Aneurysm:	
Abdominal Aorta	Yes No
Intracranial	Yes No
Thoracic Aorta	Yes No
Leg Bypass	Yes No
Carotid Artery Surgery	Yes No

PAST SURGICAL HISTORY:		**YEAR**
Abdominal:		
Appendectomy	Yes No	________
Bowel Resection	Yes No	________
Gallbladder Removal	Yes No	________
Liver Resection	Yes No	________
Pancreatic Resection	Yes No	________
ENT:		
Sinus Surgery	Yes No	________
Tonsillectomy	Yes No	________
Tracheostomy	Yes No	________
Breast:		
Lumpectomy / Mastectomy	R or L	________
GYN:		
Hysterectomy	Yes No	________
If yes, what type________________		
Removal of Tubes and Ovaries	Yes No	________
Heart:		
Pace Maker	Yes No	________
Bypass Grafts	Yes No	________
Surgery / Stent Placement	Yes No	________
Valve Replacement	Yes No	________

FAMILY HISTORY:		**Relationship**
Cancer:		
Breast	Yes No	________
Colon	Yes No	________
Lung	Yes No	________
Melanoma	Yes No	________
Skin	Yes No	________
Thyroid	Yes No	________
Ovarian	Yes No	________
Other	Yes No	________
COPD	Yes No	________
Diabetes	Yes No	________
Heart Disease	Yes No	________
High Blood Pressure	Yes No	________
High Cholesterol	Yes No	________
Kidney Failure	Yes No	________
Seizure Disorder	Yes No	________
Stroke	Yes No	________
Blood Vessel Disease	Yes No	________

Request for Treatment: Paragon Surgical Specialists maintains personnel and facilities to assist my physicians in providing me medical care and I authorize this staff to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available methods of alternative treatment, together with an explanation of the risks associated with each of them. I also have the right to ask questions regarding my care and have them answered to the best of my physician's ability. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice.

Signature: ______________________________ Date: ______________

Staff Use: Fall Risk Assessment: > 65 y.o. Yes No
Ambulatory Yes No Screening Not done for Medical Reason Yes No
Past Yr pt has had: ___ > 2 falls (1100F) ____ 1 fall w/ injury (1100F)
___ No falls (1101F) Get Up & Go Score (1-5) ___
Functioning well with vision Yes No (3288F)