Bend Surgical Associates

Michael J. Mastrangelo, MD, FACS

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICATIONS – Please list all of your current prescription, non-prescription medications, vitamins, minerals, and supplements.

O No medications

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

*** If more room is needed please use back of form or attach a list of all current medications**

Medication Allergies: (please list reaction next to allergy)

_____

_____

Please list all past Surgeries

O No previous surgeries

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

_____ **Year:** _____ **Surgeon:** _____

Patient Name: _____DOB:_____

Family History

Does anyone in your family have a history of cancer? _____

If yes what type of cancer and in which family member? _____

	Age/Age at Death	Living	Disease History/Cause of Death
Father	_____	Yes / No	_____ _____
Mother	_____	Yes / No	_____ _____
Sibling (s)	_____ _____	Yes/ No	_____ _____
Children	_____ _____	Yes/ No	_____ _____

Social History

Fill in the bubbles completely (no check marks)

- O Single O Married O Widowed O Separated O Divorced
- O Retired O Unemployed O Employed O Self-employed O Student

  Occupation: _____ If Retired, from what occupation: _____
- Smoking/Chewing Tobacco O Currently O Quit Year quit: _____ O Never

How long have you (or did you) smoke(d)? _____ How many cigarettes do you (or did you) smoke per day? _____

How often do you smoke? (Circle one) Everyday Some days

How soon after you wake up do you smoke your first cigarette? (Circle One)

5 minutes 6-30 minutes 31-60 minutes after 60 minutes

- Alcohol O Rarely O Socially O Daily O Quit O Never

  How much alcohol do you drink_____
- Recreational drugs O No O Yes O Quit If yes/Quit, what type? _____

  Current IV Drug use O No O Yes History of IV Drug use O No O Yes

Patient Name: _____DOB:_____

Past medical History:

Check all of the following that you have experienced or have ever been diagnosed with in the past:

Please fill in Circle completely (no check marks)

Heart:	**YES:**	**NO:**
Chest pain/chest tightness	O	O
Heart disease	O	O
Heart attack	O	O
Heart murmur	O	O
High Cholesterol	O	O
High blood pressure	O	O
Ear-Nose-Throat-Lungs:		
Asthma	O	O
COPD	O	O
Emphysema	O	O
Tuberculosis	O	O
General:		
Anemia	O	O
Anxiety disorder	O	O
Cancer Type: _____	O	O
Depression	O	O
Hypothyroidism	O	O
HIV	O	O
Type I diabetes – Ins. dependent	O	O
Type 2 diabetes	O	O
Lupus	O	O
Kidney/Bladder:		
Kidney stones	O	O
Kidney disease	O	O
Renal failure, acute	O	O
Renal failure, chronic	O	O

Other Medical History not listed:

_____

_____

_____

Musculoskeletal:	**YES:**	**NO:**
Arthritis	O	O
Gout	O	O
Osteoporosis	O	O
Abdomen:		
Barrett's esophagitis	O	O
Blood in stool	O	O
Cirrhosis	O	O
Colon polyps	O	O
Constipation	O	O
Diarrhea	O	O
Diverticulosis	O	O
Stomach ulcer	O	O
Fatty liver	O	O
Gall bladder disease	O	O
GI bleed, lower	O	O
GI bleed, upper	O	O
Hepatitis B	O	O
Hepatitis C	O	O
Hemorrhoids	O	O
Hernia type_____	O	O
Irritable bowel syndrome (IBS)	O	O
Ulcerative colitis	O	O
Reflux	O	O
Neurological:		
Migraines	O	O
Parkinson's disease	O	O
MS	O	O
Alzheimer’s	O	O
Stroke	O	O
Seizures	O	O

Patient Name: _____DOB:_____

Review of systems – Fill in all of the following that apply to <u>this visit today only</u>

Fill in the bubbles completely (no check marks)

Constitutional	**YES:**
Fatigue	O
Fever	O
Loss of appetite	O
Unexplained weight change	O Gain O Loss
Gastroenterology	
Abdominal pain	O
Blood in stool	O
Change in bowel habits	O
Constipation	O
Diarrhea	O
Heartburn	O
Nausea	O
Vomiting	O
Cardiology	
Chest pain	O
Dizziness	O
Palpitations	O
Shortness of breath	O
ENT/Respiratory	
Change in voice	O
Cough	O
Musculoskeletal	
Joint pain	O
Joint swelling	O
Hematology	
Unexplained Bruising	O
Easy bleeding	O

Dermatology	**YES:**
Hives	O
Skin cancer	O
Rash	O
Neurology	
Headache	O
Memory loss	O
Sleep Apnea	O
Psychology	
Anxiety	O
Depression	O
Eating disorder	O
Mental or physical abuse	O
Sexual abuse	O
Abnormal Tension/stress	O
Genitourinary female	
Increased urinary frequency	O
Difficulty urinating	O
Heavy periods	O
Painful periods	O
Number of pregnancies:	_____
Number of deliveries:	_____
Genitourinary male	
Difficulty urinating	O
Hard testicle	O
Incontinence or dribbling	O
Increased urinary frequency	O