Minnesota Surgical Associates, PA
Patient Medical History Form

Today's Date _____

INCOMPLETE INFORMATION ON THIS FORM COULD CAUSE A DELAY IN SCHEDULING A PROCEDURE OR SURGERY
PLEASE PRINT

Patient Name _____ Date of Birth _____ Age _____

Describe the symptoms/problem which is the reason for your visit _____

_____

When did this problem start _____ Are there other associated problems _____

ALLERGIES: (Please include Latex if applicable)

☐ NO ☐ YES

_____
Please list allergies

Are you taking:
☐ Aspirin ☐ Coumadin ☐ Plavix ☐ Other blood thinner
☐ Dosage and how often? _____
☐ Birth Control Pills

CURRENT MEDICATIONS

DRUG	DOSE	HOW OFTEN

PREVIOUS TESTS/PERTINENT INFORMATION

1. Have you had any other tests or x-rays which relate to your current problem ☐ Yes ☐ No
   If yes, where and date _____
   _____
2. Are you or could you be pregnant? ☐ Yes ☐ No
   Due Date
3. Do you have sleep apnea? ☐ Yes ☐ No
4. If yes, do you use a C-PAP machine or other?
   _____
5. Do you have metal anywhere in your body? (Surgical clips, artificial joints, body piercings, etc.) ☐ Yes ☐ No

REVIEW OF SYSTEMS, SURGERIES AND PAST MEDICAL HISTORY: Indicate whether you currently have a medical or surgical problem or have ever had a medical or surgical problem.

	Yes	No		Yes	No
1. Eyes (cataracts, glaucoma, etc.)	☐	☐	10. Diabetes	☐	☐
2. Ears, nose, sinuses or tonsils	☐	☐	11. Hernia	☐	☐
3. Thyroid/or parathyroid glands	☐	☐	12. Lymph nodes or spleen	☐	☐
4. Heart; angina, abnormal heart rhythm	☐	☐	13. Kidneys or bladder	☐	☐
5. Vascular (surgery, blood clots, grafts)	☐	☐	14. Bones, joints/muscles (artificial joint)	☐	☐
6. Lungs	☐	☐	15. Skin (lipomas, cysts)	☐	☐
7. Esophagus or stomach (ulcers)	☐	☐	16. Breasts (cysts, mastitis)	☐	☐
8. Bowel (small and large intestine)	☐	☐	17. High blood pressure	☐	☐
9. Liver or gall bladder	☐	☐	18. Other	☐	☐

Please describe the problems checked "YES" above, indicating present or past problem, and type of surgery and dates of surgery.

_____

_____

FAMILY MEDICAL HISTORY: Please indicate if your family has a history of.

	Yes	No		Yes	No
1. Cancer	☐	☐	3. Cardiac/Peripheral Disease	☐	☐
2. Blood Clotting	☐	☐	4. Anesthesia complications	☐	☐

CURRENT WEIGHT _____ HEIGHT _____ Have you gained or lost 15 lbs in the last six months? _____

1. Are you employed ☐ Yes ☐ No ☐ Retired Number of Children _____
   Occupation _____ Number of Brothers _____ Number of Sisters _____
   Spouse's Occupation _____
2. Are you currently married ☐ Yes ☐ No ☐ Significant Other
3. Do you ☐ Smoke ☐ Consume Alcohol ☐ Consume Caffeine ☐ Use Recreation/Street drugs