# Surgical Associates of Austin, P.A.

**Smith • Cherico • Markus • Mayer • Fleming • Ashworth • Ching • Sankar**

History and Physical Form **(Please print neatly)** Chart # ____________

Please complete numbers 1 through 16 prior to returning form to receptionist. Thank you.

**1. Patient Name:** ______________________________ Age: ________ Sex: ☐ M ☐ F
Last First Middle

**2. Chief Complaint (nurse to complete):** ______________________________

**3. Other Physicians involved in your care: Primary Care:** ______________________________
**Specialists:** ______________________________

**4. Drug Allergies:** ☐ None ☐ Yes If Yes, List drugs: ______________________________

______________________________

**5. Medications:** ☐ None ☐ See attached list if more than four (include aspirin, Motrin, etc.) ______________________________

______________________________

**6. Other Medical Problems:**
☐ None
☐ Congestive Heart Failure
☐ Prior Heart Attack
☐ Mitral Valve Prolapse
☐ Heart Rhythm Problem
☐ High Blood Pressure
☐ History of Stroke
☐ High Cholesterol / Lipids
☐ Clots in Leg Veins
☐ Diabetes
☐ Emphysema
☐ Bronchitis
☐ Asthma
☐ Heart Murmur
☐ Cancer (Type) ____________
☐ Arthritis
☐ Seizures
☐ Other: ______________________________
**(Doctor's Notes):** ______________________________

**7. Previous Operations (with last two digits of approximate year)**
☐ None
☐ Heart Valve ____
☐ Total Joint ____
☐ Gallbladder ____
☐ Appendectomy ____
☐ Groin Hernia ____
☐ Other Hernia ____
☐ Colon Surgery ____
☐ Hysterectomy ____
☐ C-Section(s) ____
☐ Breast Biopsy(ies) ____
☐ Mastectomy ____
☐ Coronary Artery Bypass ____
☐ Arthroscopy ____
☐ Spine Surgery ____
☐ Thyroid ____
☐ Cataract ____
☐ Other: ______________________________
**(Doctor's Notes):** ______________________________

**8. If female, date of last normal menstrual period:** ____________________

**9. Are you Postmenopausal?** ☐ Yes ☐ No

**10. Alcohol:**
☐ None
☐ Frequency: ____________

**11. Tobacco:**
☐ None
☐ Frequency: ____________

**12. History of IV Drug Use:**
☐ None
☐ Frequency: ____________

**13. Other Current Problems:**
☐ None
☐ Chest Pain (Heart)
☐ Irregular Heart Beat
☐ Shortness of Breath with Exertion
☐ Shortness of Breath at Night
☐ Cough
☐ Coughed Up Blood
☐ Wheezing
☐ Constipation
☐ Significant Weight Loss
☐ Change in Bowel Habits
☐ Blood in Stool Recently
☐ Diarrhea
☐ Bleeding Tendency
☐ Slurred Speech
☐ Urinary Problems
☐ Weakness (Arms / Legs)
☐ Other: ______________________________
**(Doctor's Notes):** ______________________________

**14. Names and ages of children:** ______________________________

**15. Family History of:**
☐ Breast Cancer
☐ Ovarian Cancer
☐ Lung Cancer
☐ Colon Cancer
☐ Prostate Cancer
☐ Thyroid Cancer
☐ Melanoma
☐ Skin Cancer
☐ Throat Cancer
☐ Cervix Cancer
☐ Lymphoma
☐ Leukemia
☐ Multiple Melanoma
☐ Other Cancer: ______________________________
☐ Early Age Heart Attack
☐ High Blood Pressure
☐ Diabetes
☐ Hemophilia or significant bleeding history
☐ Strokes
☐ Clots in the leg veins
☐ Gallbladder Disease

**16. I will absolutely refuse blood transfusions under any circumstances:** ☐ Yes ☐ No
☐ Other: ______________________________