Mary Washington
General Surgery and Trauma

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Patient form

Date: _____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Referring Physician: _____

Primary Care Physician: _____

Reason for Visit: _____

Past Medical History *Please check all that apply*:

- ❑ Acid Reflux/GERD
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Arrhythmia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding problems
- ❑ Cancer, type_____
- ❑ Crohn's disease
- ❑ COPD/Emphysema
- ❑ Diabetes
- ❑ Diverticulosis/Colon polyps
- ❑ ESRD (End Stage Renal Disease), Dialysis ❑ Yes ❑ No
- ❑ Heart attack, when_____
- ❑ Heart failure
- ❑ Hepatitis/Liver disease
- ❑ Hereditary disorder, type_____
- ❑ High blood pressure
- ❑ High cholesterol/Triglycerides
- ❑ HIV/AIDS/Sexually Transmitted Infection (STI)
- ❑ Other heart disease, type_____
- ❑ Other lung disease, type_____
- ❑ Overactive/Underactive thyroid
- ❑ Psychiatric diagnosis, type_____
- ❑ Sleep apnea
- ❑ Stroke, when_____

Any other medical conditions: _____

❑ Do you have a pacemaker? ❑ Do you have a defibrillator? ❑ Have you ever had problems with anesthesia?

Past Surgical History: *Please check all that apply (write the year next to the operation):*

- ❑ Adenoids _____
- ❑ Appendix _____
- ❑ Back surgery _____
- ❑ Biopsy _____
- ❑ Bladder surgery _____
- ❑ Cataracts/LASIK _____
- ❑ Cesarean _____
- ❑ CABG (heart bypass) _____
- ❑ Cardiac catherization
- ❑ Cardiac stent placement _____
- ❑ Gallbladder _____
- ❑ Colonoscopy _____
- ❑ Colon surgery _____
- ❑ Dialysis fistula _____
- ❑ Ear surgery _____
- ❑ Endoscopy (EGD) _____
- ❑ Fistula repair _____
- ❑ Heart valve replacement _____
- ❑ Hemorrhoids/Banding _____
- ❑ Hysterectomy _____
- ❑ Hernia, type _____
- ❑ Joint surgery _____
- ❑ Kidney surgery _____
- ❑ Lipoma _____
- ❑ Lung surgery _____
- ❑ Ostomy creation/reversal _____
- ❑ Pacemaker/Defibrillator_____
- ❑ Pilonidal surgery _____
- ❑ Port placement _____
- ❑ Prostate surgery _____
- ❑ Thyroid _____
- ❑ Tonsils _____
- ❑ Tubal ligation _____

Any surgeries not mentioned:

Type: _____

_____

When: _____

Family History:

Relationship	Medical Problem
Mother	
Father	
Mother's father	
Mother's mother	
Father's father	
Father's mother	
Aunts/uncles	
Siblings	
Children	
Great-grandparents	

Social History:

Occupation:_____

Tobacco use: ❑ Yes ❑ Former ❑ No Please specify: ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Vape ❑ Chewing tobacco ❑ Snuff

- If yes or former, how many packs per day _____ for how long _____
- If former, when did you quit? _____

Alcohol use: ❑ Yes ❑ Former ❑ No

- If yes or former, how much per day _____week _____
- If former, when did you quit? _____

Recreational Drugs: ❑ Yes ❑ Former ❑ No

- If yes or former, which drug(s) and how often _____
- If former, when did you quit? _____

Sexually Active: ❑ Yes ❑ Not Currently ❑ Never

- Partner(s): ❑ Male ❑ Female
- Birth control/protection: ❑ Yes ❑ No
  Type _____

Socioeconomic:

Marital Status: ❑ Single ❑ Married ❑ Legally Separated ❑ Divorced ❑ Widowed ❑ Significant other

- Spouse's/Partner's name who we can speak with or release information to regarding your care
  _____

Number of Children: _____
Primary language: _____

Females:

Are you currently pregnant? ❑ Yes ❑ No
Are you still having periods? ❑ Yes ❑ No

- If yes, when was your last menstrual period? _____

Allergies	Reaction

Medications:

Please include all prescribed, supplements and OTC

Medication	Dose	Frequency

Preferred Local Pharmacy: _____

List of Other Providers

Gastroenterologist: _____

Cardiologist: _____

Pain management provider: _____

Pulmonologist: _____

Hematologist/Oncologist: _____

Dermatologist: _____

Nephrologist: _____

Otolaryngologist (Ear Nose & Throat): _____

Neurologist: _____

Rheumatologist: _____

Endocrinologist: _____

Urologist: _____

Infectious Disease: _____

Orthopedist: _____

Psychiatrist: _____

Allergist/Immunologist: _____

Other: _____

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