

PORTLAND SURGICAL ASSOCIATES
Christopher D. Rogers, D.O., F.A.C.O.S.
Benjamin L. Russell, D.O., F.A.C.O.S.
Melissa Tsomides, PA-C

Name: _____ **Age:** _____ **Birth date:** _____ **Today's Date:** _____

Family Physician: _____

During your examination would you like to have a female chaperone in the exam room with you? Y / N

Present Complaint: _____

Previous Surgeries: _____

Medications: (Include dosage and frequency) _____

Allergies: _____

Social History:

Do you smoke? Yes/No _____ packs/day
 Do you use recreational drugs? Yes/No
 Have you ever had a blood transfusion? Yes/No

Do you drink alcohol? Yes/No
 Do you have any TB/HIV/AIDS risk factors? Yes/No
 Occupation _____

Your Previous Illnesses:

- Cancer (Type: _____)
- Diabetes
- Heart Attack/Disease
- High Blood Pressure
- Asthma/Emphysema
- Gallbladder Disease
- Bowel Disorders
- Bladder Disorders
- Hepatitis / Jaundice
- TB / HIV / AIDS
- Seizures
- Thyroid Problems
- Bleeding Disorders
- Phlebitis
- (Other) _____

Family History: Mother: dead / alive
 Father: dead / alive
 Sister(s): _____
 Brother(s): _____

Has anyone in your FAMILY ever had:

- Cancer (type: _____)
- Diabetes
- Heart Attack / Disease
- High Blood Pressure
- Asthma / Emphysema
- Gallbladder Disease
- Bowel Disorders (Type: _____)
- Hepatitis / Jaundice
- TB / HIV / AIDS
- Birth Defects
- Bleeding Disorders

In the past six (6) months have you experienced any of the following?

- | | | | |
|--|--|---|---|
| HEENT <input type="checkbox"/> Headaches | CV <input type="checkbox"/> Chest Pain | NMS <input type="checkbox"/> Muscle pain | GI <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Sinus pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Numbness | <input type="checkbox"/> Food intolerance |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Leg pains with walking | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Sore throat | | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Diarrhea |
| RESP <input type="checkbox"/> Shortness of breath | GU <input type="checkbox"/> Pain with urination | | <input type="checkbox"/> Weight loss / gain |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Blood in urine | | <input type="checkbox"/> Changed bowel habits |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Bladder infections | GYN Date of last period _____ | |
| ENDC <input type="checkbox"/> Rashes | <input type="checkbox"/> Sexual problems | Age of first period _____ | |
| <input type="checkbox"/> Temperature intol | <input type="checkbox"/> Penile / Vaginal discharge | Number of pregnancies _____ | |
| <input type="checkbox"/> Skin flushing | <input type="checkbox"/> Testicular masses / pain | Breast pain / mass / nipple discharge _____ | |
| <input type="checkbox"/> Excessive thirst/urination | | | |

Year of last Colonoscopy _____

Year of last Mammogram _____

Date/Reviewer _____