Medical History

Palmetto Health USC
WEIGHT MANAGEMENT CENTER

Please fill out the entire form. One of our staff can help you with any questions you may have about the form. The information that you provide will be helpful to your surgeon in making decisions concerning your health. Some questions are repetitive but please answer all questions and fill in all blanks. Your doctor or nurse may ask you to give more detail (orally) about certain "positive" answers.

Patient Info

Patient_____ Date_____ Age_____ DOB_____

Name of doctor who referred you to this office_____

Name of regular physician_____ Name of cardiologist, if any_____

Name of dialysis center_____ Days you go_____

Brief description of problem for which you were referred_____

Please list all medications and supplements Including dosages and number of doses taken daily (May attach separate paper)

List any drug and food allergies (including latex and tape)

Check below, for each item that may pertain to you:

☐ Y ☐ N Heart Surgery ☐ Y ☐ N Pacemaker ☐ Y ☐ N Defibrillator ☐ Y ☐ N Hysterectomy

☐ Y ☐ N Gallbladder Surgery ☐ Y ☐ N Appendix Surgery ☐ Y ☐ N Hernia Surgery ☐ Y ☐ N Cancer

List all other prior surgical operations and appropriate dates (May exclude minor orthopedic, dental and skin operations)

List prior major illnesses and Injuries including approximate dates (Please be brief)

Social History (Circle One)

Marital status: Single Married Divorced Widowed

Names of individuals living with you_____

Occupation_____

Smoker? ☐ Y ☐ N Packs per day_____ If not a smoker, did you previously smoke? ☐ Y ☐ N Quit date_____

Alcohol use (circle one): Never Occasional Moderate Heavy

Are you disabled? ☐ Y ☐ N If yes, what is the disability?_____

Office Use Only:

BP_____ Height_____ Weight_____

Pulse_____ Temp_____ Respiration_____

Name_____ Chart #_____

Reveiwed by_____, MD Date_____

Reviewed by_____, MD Date_____

Family History

List the predominant health problems affecting the following relatives.
(Consider cancer, hypertension, diabetes, morbid obesity, heart attack, stroke, and kidney failure). Be brief.

Father_____

Mother_____

Brother(s)_____ Sister(s)_____

Review of Systems

Check the symptoms and/or diagnoses that apply to you. You may write in symptoms and diagnoses, as well.

☐ Y ☐ N **General Symptoms:** recent fever, unintended weight loss, fibromyalgia, chronic fatigue_____

☐ Y ☐ N **Immunologic/Allergies:** HIV/AIDS, lupus, sarcoidosis_____

☐ Y ☐ N **Hematologic/Lymphatic:** anemia, leukemia, lymph node enlargement, lymphedema, deep venous thrombosis, phlebitis pulmonary embolus (blood clots in lungs), easy bruisings_____

☐ Y ☐ N **Endocrine/Glands:** diabetes, thyroid problems, adrenal problems_____

☐ Y ☐ N **Psychiatric:** major depression, minor depression, psychosis, anxiety disorder, bipolar illness_____

☐ Y ☐ N **Heart and Blood Vessels:** prior heart attack, angina, chest pains, heart valve problems, aneurysms, artery occlusions or narrowings, vein problems, irregular heartbeat, high cholesterol, high blood pressure_____

☐ Y ☐ N **Respiratory:** COPD, emphysema, asthma, sleep apnea, persistent cough, persistent hoarseness, Tuberculosis_____

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☐ Y ☐ N **Gastrointestinal:** diverticulosis, diverticulitis, constipation, diarrhea, irritable bowel syndrome, colitis, gastroesophageal reflux disease, peptic ulcer disease, gallbladder problems, liver problems (cirrhosis, hepatitis, other), intestinal obstruction, nausea, vomiting

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☐ Y ☐ N **Genitourinary:** kidney failure, kidney stones, kidney transplant, prostate problems, ongoing gynecological problems_____

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☐ Y ☐ N **Musculoskeletal:** arthritis (severe, not severe), deformities, braces, walking aids, muscle abnormalities_____

☐ Y ☐ N **Skin:** recurrent infections, psoriasis, other_____

☐ Y ☐ N **Are you currently being treated for MRSA (Methicillin Resistant Staphylococcus Aureus)?**_____

If no, have you been treated for MRSA in the past? ☐ Y ☐ N_____

☐ Y ☐ N **Breasts:** prior cancer, prior biopsies, current mass, current pain_____

☐ Y ☐ N **Neurological:** stroke, headache problems, neuropathy, poor balance, seizures_____

☐ Y ☐ N **Eyes:** nearsighted, glasses, contacts, partial or total blindness, glaucoma_____

☐ Y ☐ N **Ears, Nose, Mouth, Throat:** pain, deafness, hoarseness, frequent nosebleeds_____

☐ Y ☐ N **Do you have diabetes?**_____

☐ Y ☐ N **Do you take any blood thinners such as Coumadin, Heparin, or Plavix?**_____

☐ Y ☐ N **Do you have mitral valve prolapsed?**_____

☐ Y ☐ N **Are you being treated for hypertension?**_____