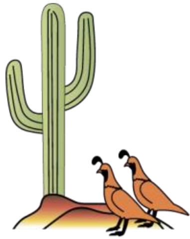

Saguaro Surgical

General, Robotic, Endocrine, Breast & Vascular Surgery

NEW PATIENT MEDICAL HISTORY FORM

Name: ____Age/DOB: _________________Sex: _________

Referring Doctor: ____Today's Date: ________________

Reason for today's visit: ____

Current Height _______________ Current Weight _______________ Weight one year ago _________________

Current and Past Medical Problems: (please circle Yes or No)

Yes No * Diabetes - If Yes, What Type? ______________When were you diagnosed? ______________
Yes No * Angina (chest pain)
Yes No * High Blood Pressure
Yes No * Stroke- If Yes, when?________________Any paralysis or deficit? ____________________
Yes No * Heart Disease If Yes, What Type? _______________________________________
Yes No * Epilepsy or Seizures? If Yes, What Type? _______________________________________
Yes No * Cancer? If Yes, What Type? _______________________________________
Yes No * Lung Disease? If Yes, What Type? _______________________________________
Yes No * Kidney Problems? If Yes, What Type? _______________________________________
Yes No * GI Disorders? If Yes, What Type? _______________________________________
Yes No * Hepatitis? If Yes, What Type? _______________________________________
Yes No * Anemia or Blood Disorders? If Yes, What Type? _______________________________________
Yes No * Phlebitis or Blood Clots? If Yes, What Type? _______________________________________
Yes No * Thyroid Disease? If Yes, What Type? _______________________________________
Yes No * Arthritis? If Yes, What Type? _______________________________________
Yes No * Visual Impairment? If Yes, What Type? _______________________________________
Yes No * Mental Health Condition If Yes, What Type?_______________________________________
Yes No * Do you have a Pace Maker?
Other: ____
Past Surgical History (please include dates): ____
____
Have you ever had a blood transfusion? Yes No If Yes, Any Reactions? _________________________
Have you ever had general anesthesia? Yes No If Yes, Any Reactions? _________________________

PLEASE LIST ALL MEDICATIONS AND DOSAGES: ____
____
Please circle if you are taking any of the following: Coumadin Daily Aspirin Diabetes Medication
Are you allergic to any medications? Yes No If Yes, Any Reactions? ______________________________

Social History: Alcohol Use: Yes No How many / How often? ______________________________
Do you smoke? Yes No If Yes, packs per day?_____ How many years _____ If quit, when ________________

Date of Last Chest X-Ray ______________ Last EKG ______________ Last Mammogram ________________