Olde Del Mar Surgical Medical Group, Inc.
Personal History

Patient's Name:_____ Date:_____
Date of Birth:_____ Age_____ Sex_____
Referred by: _____ Marital Status_____
Occupation:_____ Employer:_____
Current height:_____ Current weight:_____

CHIEF COMPLAINT- Please describe the reason for your visit today:

_____

MEDICATIONS- Please list the name, strength, and number of times taken daily:

medication	dosage	how often?	date started ?

Aspirin every day? ___Yes ___No Date of last dosage: _____
Plavix every day? ___Yes ___No Date of last dosage: _____
Coumadin every day? ___ Yes ___ No Date of last dosage: ____
Others: _____

ALLERGIES- include all allergies:

Do you have any allergies to medications? ____ Yes ____ No
If so, please list: _____
Other: _____ Iodine? ___ Shellfish? ___ Surgical Tape? ___

SURGICAL HISTORY- Please list any prior surgeries chronologically (include year)

1. _____Date:_____
2. _____Date:_____
3. _____Date:_____
4. _____Date:_____
5. _____Date:_____

MEDICAL HISTORY- Have you ever had any of the following? When?

Asthma ___ Yes ___ No Rheumatic Fever ___ Yes ___ No Hepatitis ___ Yes ___ No What Type: __
Diabetes ___ Yes ___ No Seizures ___ Yes ___ No Blood Clots/Bleeding ___ Yes ___ No
Heart Attack ___ Yes ___ No Strokes ___ Yes ___ No Anemia ___ Yes ___ No
High Blood Pressure ___ Yes ___ No Tuberculosis ___ Yes ___ No
Pneumonia ___ Yes ___ No Thyroid disorder ___ Yes ___ No
Cancer? ___ Yes ___ No If yes, what type?_____
Date of last colonscopy: _____
Anesthesia problems ___Yes ___ No Describe: _____
Please list any other illness or hospitalizations: _____

****Please see reverse to complete additional information)****

FEMALE PATIENTS ONLY:

# of Pregnancies: ___ Age at first period: ___ Date of last period: _____ Age at menopause: _____
# of Live births: ___ # of Miscarriages/Abortions: ___ # of Csections: ___ Bra size: _____
Obstetric complications: _____

When was your last mamogram? Date: _____ Results: _____
When was your last pap/pelvic exam? Date: _____ Results: _____

Do you presently use:
Fertility Medications: ___Yes ___No Years taken: _____ List Type(s): _____
Birth Control Pills: ___ Yes ___ No Years taken:___ List Type(s):_____
Estrogens: ___Yes ___ No Years taken: ___ List Type(s): _____
Other Contraceptive method(s): _____

SOCIAL HISTORY:

Alcohol? ___ Yes ___ No If yes, number of drinks per day:_____
Smoker? ___ Yes ___ No If yes, how many packs a day? ___ If former smoker, year quit: _____
Drugs? ___ Yes ___ No
Coffee? ___ Yes ___ No If yes, cups per day _____
Tea? ___ Yes ___ No If yes, cups per day _____
Soda? ___ Yes ___ No If yes, cups per day _____
Chocolate? ___ Yes ___ No
Regular exercise? ___ Yes ___ No How often: _____
Any history of abuse: ___ Yes ___ No
Religious practice that will affect your care plan: ___ Yes ___ No Yes, explain: _____

FAMILY HISTORY:

RELATION	AGE	ANY ILLNESSES	IF DECEASED, AGE & CAUSE OF DEATH
Mother			
Father			
Brother(s)			
Brother(s)			
Sister(s)			
Sister(s)			
Children			
Children			
Children			

Patient Signature: _____Date:_____

2/25/2014