PARAGON SURGICAL SPECIALISTS DATE: _______________

Name: ____________________________________ Birth Date:____/____/____

Primary Care Physician: ________________________ Local Pharmacy: _____________________________

Height ______ Weight ________ Gender Identity: ☐ Male ☐ Female ☐ Other

Race/Ethnicity *(check one or more):*

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ Hispanic / Latino ☐ Asian ☐ White or Caucasian

Language Preference: English / Spanish or Other: _______________

Advanced Directives/Living Will: Yes / No *If yes, what type?* ______________

Medications	Dosage	Amt/Day	Medications	Dosage	Amt/Day

ALLERGIES:

Medication Allergies: Yes or No *If Yes, Please List*: ____

Food Allergies: Yes or No *If Yes, Please List*: ____

Other Allergies: ☐ Adhesive Tape ☐ Latex ☐ Shellfish ☐ Betadine ☐ Others _________________

Reason for Today's Visit: ____ Is this a work-related injury? Yes No

CURRENT COMPLAINTS:

General:
- Fatigue Yes No
- Fever Yes No
- Weight Gain Greater than 10 lbs Yes No
- Weight Loss Greater than 10 lbs Yes No

Skin:
- Hair Loss Yes No
- Rash Yes No
- Skin Color Changes Yes No

HEENT:
- Head Injury Yes No
- Visual Loss Yes No
- Hearing Loss Yes No
- Hoarseness Yes No
- Sore Throat Yes No

Neck:
- Neck Mass Yes No
- Swollen Glands Yes No

Respiratory:
- Chronic Cough Yes No
- Difficulty Breathing Yes No
- Wheezing Yes No

Breast:
- Breast Mass Yes No
- Breast Pain Yes No
- Breast Swelling Yes No
- Nipple Discharge Yes No
- Skin Changes On the Breast Yes No

Gastrointestinal:
- Abdominal Pain Yes No
- Bloody Stool Yes No
- Constipation Yes No
- Diarrhea Yes No
- Difficulty Swallowing Yes No
- Heartburn Yes No
- Indigestion Yes No
- Vomiting Yes No
- Nausea Yes No

Genitourinary: Male:
- Change in urinary stream Yes No
- Incontinence Yes No
- Painful Urination Yes No
- Testicular mass Yes No
- Testicular pain Yes No

Genitourinary: Female:
- Are you pregnant Yes No
- Vaginal Bleeding Yes No
- Painful Urination Yes No
- Incontinence Yes No
- Blood in Urine Yes No
- Discharge Yes No

Musculoskeletal:
- Back Pain Yes No
- Joint Pain Yes No
- Joint Stiffness Yes No
- Joint Swelling Yes No
- Muscle Weakness Yes No

Neurological:
- Seizures Yes No
- Stroke Yes No
- Weakness in extremities Yes No

Psychiatric:
- Anxiety Yes No
- Depression Yes No
- Panic Attacks Yes No

Endocrine:
- Blurred Vision Yes No
- Excessive Thirst Yes No
- Thyroid Problems Yes No

Hematology:
- Blood Clots Yes No
- Easy Bruising Yes No
- Enlarged Lymph Nodes Yes No
- Prolonged Bleeding Yes No

Social History:
- Alcohol Use Yes No
- Drug Use Yes No
- Smoker Yes No
  - If Yes, amount? ______

Cardiovascular:
- Chest Pain Yes No
- Palpitation Yes No
- Swelling of Extremities Yes No

Health Maintenance:

Last Mammogram:

Date/Years ago _____

Last Colonoscopy:

Date/Years ago _____

PAST MEDICAL HISTORY:

Condition	Yes No
Arthritis	Yes No
Asthma	Yes No
Bleeding Tendency	Yes No
If yes what type?__________	
Blood Clots If yes, Legs	Yes No
Lung	Yes No
Cancer:	Yes No
If yes what type?__________	
Radiation	Yes No
Chemotherapy	Yes No
COPD (Cardiopulmonary Disease)	Yes No
Diabetes	Yes No
Heart Attack	Yes No
Hepatitis	Yes No
High Blood Pressure	Yes No
High Cholesterol	Yes No
HIV/AIDS	Yes No
Kidney Failure	Yes No
If yes on Dialysis?	Yes No
Malignant Hyperthermia	Yes No
MRSA	Yes No
Seizure Disorder	Yes No
Stroke	Yes No

Hernia:	**R L**
Groin/Inguinal	Yes No
Hiatal	Yes No
Incisional	Yes No
Navel / Umbilical	Yes No
OB:	
C-section Tubal	Yes No
Ligation	Yes No
Orthopedic:	
Any Metal Rods/Plates	Yes No
Total Hip	Yes No
Total Knee	Yes No
Total Shoulder	Yes No
Thoracic:	
Esophageal Resection	Yes No
Lung Resection	Yes No
Vascular:	
Aneurysm:	
Abdominal Aorta	Yes No
Intracranial	Yes No
Thoracic Aorta	Yes No
Leg Bypass	Yes No
Carotid Artery Surgery	Yes No

PAST SURGICAL HISTORY:		**YEAR**
Abdominal:		
Appendectomy	Yes No	________
Bowel Resection	Yes No	________
Gallbladder Removal	Yes No	________
Liver Resection	Yes No	________
Pancreatic Resection	Yes No	________
ENT:		
Sinus Surgery	Yes No	________
Tonsillectomy	Yes No	________
Tracheostomy	Yes No	________
Breast:		
Lumpectomy / Mastectomy	R or L	________
GYN:		
Hysterectomy	Yes No	________
If yes, what type________________		
Removal of Tubes and Ovaries	Yes No	________
Heart:		
Pace Maker	Yes No	________
Bypass Grafts	Yes No	________
Surgery / Stent Placement	Yes No	________
Valve Replacement	Yes No	________

FAMILY HISTORY:		**Relationship**
Cancer:		
Breast	Yes No	________
Colon	Yes No	________
Lung	Yes No	________
Melanoma	Yes No	________
Prostate	Yes No	________
Pancreatic	Yes No	________
Skin	Yes No	________
Thyroid	Yes No	________
Ovarian	Yes No	________
Other	Yes No	________
COPD	Yes No	________
Diabetes	Yes No	________
Heart Disease	Yes No	________
High Blood Pressure	Yes No	________
High Cholesterol	Yes No	________
Kidney Failure	Yes No	________
Seizure Disorder	Yes No	________
Stroke	Yes No	________
Blood Vessel Disease	Yes No	________

Request for Treatment: Paragon Surgical Specialists maintains personnel and facilities to assist my physicians in providing me medical care and I authorize this staff to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available methods of alternative treatment, together with an explanation of the risks associated with each of them. I also have the right to ask questions regarding my care and have them answered to the best of my physician's ability. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice.

Signature: ______________________________ **Date:** ________________

Staff Use: Fall Risk Assessment: > 65 yrs Yes No **Ambulatory** Yes No **Screening Not done for Medical Reason** Yes No
Past Yr pt has had:______> 2 falls (1100F) ___1 fall w/ injury (1100F) ___No falls (1101F) Get Up & Go Score (1-5) ____
Functioning well with vision Yes No (3288F)