WICHITA SURGICAL SPECIALISTS, P.A.

Patient Name:_____ DOB:_____ Age: ___ Today's Date_____

Email address:_____

Family Doctor:_____ Referring Doctor:_____

Describe your main problem(cc)_____

_____

Where is your problem located? _____

Describe the quality of your problem (sharp, cramping, stabbing, throbbing, hot, shooting, etc_____

Rate the severity of the problem: Mild> 0-1-2-3-4-5-6-7-8-9-<Severe (severity)_____

How long have you had this problem? (duration)_____

How often does this problem occur? (2x daily, constant, intermittent, sporadic, frequent, timing _____

Where were you/what were you doing at the onset of the problem? (context)_____

What Medication or action was taken to change the signs/symptoms? Did that help? (modifying factors)_____

Any associated signs/symptoms?(nausea, fever, radiating pain)_____

List previous hospitalizations/Surgeries/Serious Injuries When?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Patient Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Socially ☐ Daily_____

Use of tobacco: ☐ Never ☐ Previously quit ☐ Current packs per day _____

Occupation: _____ Full time/Part time Caffeine:____ cups/day

Family Medical History:

	Age	Health Issues	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Have you ever had the following?

Diabetes……..yes no
High Blood Pressure…….yes no
Cancer/Type……..……
Stroke……...yes no
Heart trouble……...yes no
Arthritis……yes no
Gout……..yes no
Convulsion...……..yes no
Bleeding tendency……. yes no
Acute infections……..yes no
Venereal disease……yes no
Hereditary defects……..yes no
Colonoscopy……yes no
Year:___ Positive:__ Negative:__
Mammogram……...yes no
Year:___

Current Medications, dosage, and frequency:

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____
11)_____
12)_____
13)_____
14)_____
15)_____

Continue on the back if needed:Y/N

Allergies – medication, food, etc:

1)_____
2)_____
3)_____
4)_____
5)_____