# Lancaster Surgical Group LSG002

## Patient Demographics

 Date:

**Patient Name: Last ______________________________ First: _____________________MI: __________**
**Date of Birth: ________________________ Age: _________ Social Security #: ___________________**
**Medication Allergies: Yes or No What to? ________________________________________________**

**As a patient of Lancaster Surgical Group, we would like to thank you for taking the time to complete our questionnaires. The following information is very important to your health. Please take time to fully and completely fill out this information. We are counting on you. You will be asked at your return appointments if any of this information has changed. If you are not asked to review and update this information, please inform your surgeon of any change in medical condition or medications.**

## Referral Information

**Requesting Physician:**

________________________________________________________________________

**Family Physician (if different):**

________________________________________________________________________

**Reason for Exam/ Chief Complaint:** ____________________________________________

## Past, Family and Social History

**Previous Surgery and Procedures:** ***(What, When, Where, Type Anesthesia)***

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Current Medications:**

| | Name | Dosage | How Often? | Why? |
|---|---|---|---|---|
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |
| ❑ | | | | |

## Social History:

**Occupation:** ______________________________

**Does your job require heavy lifting?** ______________________________

**Do you spend a lot of time on your feet?** ______________________________

**Duties:**______________________________

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| | *Yes* | *No* | *Amount/Number Years* | *Quit* |
|---|---|---|---|---|
| **Alcohol Use:** | | | | |
| **Tobacco Use:** | | | | |
| **Cigarette:** | | | | |
| **Cigar:** | | | | |
| **Pipe:** | | | | |
| **Oral/Snuff:** | | | | |
| **Drug Use:** | | | | |

## Family History:

*Check All Boxes Applicable*

| Disease | *You* | *Family* | | | *You* | *Family* |
|---|---|---|---|---|---|---|
| High Blood Pressure | ❒ | ❒ | | | | |
| Heart Disease | ❒ | ❒ | | | | |
| Angina | ❒ | ❒ | | | | |
| Heart Attack | ❒ | ❒ | When?____________ | | | |
| High Cholesterol | ❒ | ❒ | How high? ____________ | | | |
| High Lipids | ❒ | ❒ | How high?____________ | | | |
| Atrial Fibrillation | ❒ | ❒ | | Breast Cancer | ❒ | ❒ |
| Stroke | ❒ | ❒ | | Lung Cancer | ❒ | ❒ |
| Seizure Disorder | ❒ | ❒ | | Colon Cancer | ❒ | ❒ |
| Hepatitis | ❒ | ❒ | | Prostate Cancer | ❒ | ❒ |
| Bleeding Problems | ❒ | ❒ | | Other Cancer | ❒ | ❒ |
| Asthma | ❒ | ❒ | | Chemotherapy | ❒ | ❒ |
| Emphysema | ❒ | ❒ | | Radiation Therapy | ❒ | ❒ |
| Diabetes | ❒ | ❒ | | Anesthesia Problems | ❒ | ❒ |
| Thyroid Disease | ❒ | ❒ | | Arthritis | ❒ | ❒ |
| Kidney Disease | ❒ | ❒ | | Alcoholism | ❒ | ❒ |
| AIDS/HIV | ❒ | ❒ | | Mental Illness | ❒ | ❒ |

**Further Explanation if Applicable:**

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## Review of Systems
***Circle all applicable***

**Constitutional:** fever weight loss/gain fatigue chills night sweats
**Eyes:** eye disease/injury wears glasses/contact lenses blurred vision
Glaucoma spots blindness double vision
**Ears, Nose, Throat:** hearing loss/ringing earaches/drainage nose bleeds
mouth sores bleeding gums bad breath/taste sore throat
voice change swollen glands in neck chronic sinus problems
snoring hoarseness
**Respiratory:** cough asthma wheezing shortness of breath
spitting/coughing up blood tuberculosis
**Cardiovascular:** rapid heart beat chest pain/angina heart murmur
palpitations swelling of feet/ankles/hands pacemaker
**Gastrointestinal:** nausea vomiting heartburn diarrhea ulcers
change in bowel habits painful bowel movements constipation
rectal bleeding jaundice abdominal pain appetite loss
**Genitourinary:** difficult urination impotence menstrual pain
frequent urination incontinence/dribbling testicular pain
kidney stones bloody urine
**Musculoskeletal:** joint pain back pain stiffness swelling bone pain
weakness muscles pain difficulty walking
**Integumentary (Skin, Breast):** rashes itching changes in skin color
change in hair/nails unusual looking lesions ulcers easy bruising
varicose veins skin cancer breast pain breast lump nipple discharge
**Neurological:** tremors dizziness memory loss head injury stroke
tingling/numbness migraines/headaches seizures paralysis fainting
**Psychiatric:** memory loss insomnia depression mood swings anxiety
**Endocrine:** excessive thirst excessive urination heat intolerance cold intolerance
**Hematological, Lymphatic:** bruising easily bleeding problems blood clots phlebitis
anemia past transfusion large lymph nodes
**Allergic, Immunology:** hives sneezing runny nose itchy eyes seasonal allergies
frequent colds

* All systems negative if not circled – per patient*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

**Patient Signature:** ______________________________________________ **Date:** __________

**Physician Signature:** ____________________________________________ **Date:** __________

***Breast Questionnaire*** _____ ***Vascular Questionnaire*** _____ *Medical Assistant Initials:* ______________