

**DALLAS SURGICAL GROUP**  
**Peter D. Beitsch, MD, FACS**

Name \_\_\_\_\_

Date \_\_\_\_\_

**Problem you are here for:**

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**Please answer *all* of the following questions to the best of your ability:**

Name of your Primary Care Doctor \_\_\_\_\_

Name of your Gastroenterologist \_\_\_\_\_

Name of your Medical Oncologist \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Address and/or Phone # \_\_\_\_\_

Initial \_\_\_\_\_

Name \_\_\_\_\_

**PAST SURGERY (Operations)**

Please list in chronological order. Check here if no prior surgery \_\_\_\_\_

Date	Operation	Hospital/Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PAST MEDICAL HISTORY**

Have you ever had (check all that apply):

- |   |   |                                    |                                    |
|---|---|------------------------------------|------------------------------------|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Asthma    |
| <input type="checkbox"/> Angina (chest pain)  | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Seizure   | <input type="checkbox"/> Cancer    |
| <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Heart Failure    | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other Heart Problems | <input type="checkbox"/> Organ Transplant |                                    |                                    |

**MEDICATIONS**

Please list all the medications you take. Include aspirin, and over the counter medications. Check here if none \_\_\_\_\_

Name	Dosage	# of times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**VITAMINS/HERBAL SUPPLEMENTS**

Some vitamins and herbal supplements can cause increased bleeding during and after surgery. Please note if you take any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fish Oil/Omega 3 | <input type="checkbox"/> Aspirin/Advil | <input type="checkbox"/> Ginkgo Biloba   |
| <input type="checkbox"/> Garlic           | <input type="checkbox"/> Ginseng       | <input type="checkbox"/> Vitamin E       |
| <input type="checkbox"/> Ephedra          | <input type="checkbox"/> Echinacea     | <input type="checkbox"/> St. John's Wort |
| <input type="checkbox"/> Valerian         | <input type="checkbox"/> Kava          |  |

**ALLERGIES**

Please list all of your allergies. Check here if none \_\_\_\_\_

Substance	Effect
_____	_____
_____	_____
_____	_____

**SOCIAL HISTORY**

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_  
Do you drink? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Initial \_\_\_\_\_

Name \_\_\_\_\_

**REVIEW OF SYMPTOMS**

Are you *currently* experiencing any of these symptoms (please check all that apply)?

**Constitutional Symptoms**

Fever  Night Sweats  Weight Loss

**Eyes**

Glaucoma  Cataracts

**Ear, Nose, Mouth and Throat**

Ear Problems  Sinus Problems  Bleeding Gums  
 Painful Swallowing  Change in voice

**Cardiovascular**

High Blood Pressure  Blood Clot in Legs  Chest Pain  
 Heart Attack  Leg Pain when Walking  Heart Murmur  
 Irregular Heart Beats  Congestive Heart Failure

**Respiratory**

Asthma  Emphysema

**Gastrointestinal**

Difficulty Swallowing  Peptic Ulcers  Nausea/Vomiting  
 Liver Disease  Hepatitis

**Genitourinary**

Kidney Stones  Kidney Infection  
Men: Difficulty Urinating/enlarged prostate  Women: Abnormal Bleeding

**Musculoskeletal**

Arthritis  Osteoporosis

**Skin**

Psoriasis  Skin Cancer  Melanoma

**Breast**

Breast Lumps  Nipple Discharge  Breast Pain

**Neurological**

Headaches  Stroke  Seizures  
 Migraines

**Psychiatric**

Depression

**Endocrine**

Diabetes  Temperature Intolerance

**Hematologic/Lymphatic**

Anemia  Blood Clotting Problem  Daily Aspirin

**Allergy/Immune System**

Immune Deficiency  Latex Allergy

Initial \_\_\_\_\_

Name \_\_\_\_\_

**FAMILY HISTORY**

Please include such items as:

- |              |                 |                |                     |
|--------------|-----------------|----------------|---------------------|
| Lung Cancer  | Breast Cancer   | Other Cancer   | Heart Attack        |
| Colon Cancer | Prostate Cancer | Kidney Disease | High Blood Pressure |
| Melanoma     | Ovarian Cancer  | Diabetes       | Strokes             |

	<u>Living/Age</u>	<u>Deceased/Age</u>	<u>Medical Problems</u>
Parents:			
Father	_____	_____	_____
Mother	_____	_____	_____

Brothers:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sisters:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Children:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Initial \_\_\_\_\_