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

Name_______________________________________________ Date________________________

**Problem you are here for:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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

Have you ever been diagnosed with any of the following?

Basal Cell Carcinoma _______
If yes, where on your body? ____________________________________ When? ________

Squamous Cell Carcinoma _______
If yes, where on your body? ____________________________________ When? ________

Melanoma _______
If yes, where on your body? ____________________________________ When? ________

Have you had any previous severe sunburns? ____ YES ____ NO

Has anyone in your family been diagnosed with **melanoma**? ____________
If yes, who? __________________________________________________________________
______________________________________________________________________________

Name of your Obstetrician/Gynecologist ______________________________________________

Name of your Primary Care Doctor __________________________________________________

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):

| | | | |
|---|---|---|---|
| ___ High Blood Pressure | ___ Diabetes | ___ Stroke | ___ Asthma |
| ___ Angina (chest pain) | ___ Kidney Disease | ___ Seizure | ___ Cancer |
| ___ Heart Attack | ___ Heart Failure | ___ Emphysema | ___ Hepatitis |
| ___ Other Heart Problems | ___ 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:

| | | |
|---|---|---|
| ___Fish Oil/Omega 3 | ___Aspirin/Advil | ___Ginkgo Biloba |
| ___Garlic | ___Ginseng | ___Vitamin E |
| ___Ephedra | ___Echinacea | ___St. John's Wort |
| ___Valerian | ___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 |

| | Living/Age | Deceased/Age | Medical Problems |
| --- | --- | --- | --- |

Parents:

Father ______________________________________________________________________________

Mother ______________________________________________________________________________

Brothers:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Sisters:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Children:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**PATIENT SIGNATURE ______________________________________ DATE _____________**

Initial ____