David Bub, MD, PC, FACS, FASCRS

Medical History Form

Date: _________________

PATIENT NAME: ____ Date of Birth: _________________________

How did you hear about us?: _________________________ Primary Care Provider: ___________________________

Other Treating Physicians: ____

ALLERGIES: Please list all medications, latex, dyes, foods, etc.

Allergy List	Reaction
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________

MEDICATIONS: Please list all medications & drugs including over the counter, herbal supplements, vitamins.

Name	Dosage/Amount	Frequency

DO YOU HAVE OR HAVE YOU HAD:

__Y __N Acid Reflux
__Y __N Anxiety Disorder
__Y __N Asthma
__Y __N Atrial Fibrillation
__Y __N Bleeding Disorder
__Y __N Cancer – What type? ___________________
__Y __N Coronary Artery Disease
__Y __N Coronary Stents
__Y __N Deep Vein Thrombosis (blood clot leg)
__Y __N Defibrillator
__Y __N Depression
__Y __N Diabetes, Insulin
__Y __N Diabetes, Non-Insulin
__Y __N Diverticulitis
__Y __N Drug Addiction
__Y __N Emphysema
__Y __N Fibromyalgia
__Y __N Glaucoma
__Y __N Gout
__Y __N Heart Attack
__Y __N Heart Murmur
__Y __N Hepatitis
__Y __N Hiatal Hernia
__Y __N High Blood Pressure
__Y __N High Cholesterol
__Y __N HIV or AIDS
__Y __N Hypothyroidism
__Y __N Kidney Disease
__Y __N Kidney Stones
__Y __N Leukemia/Lymphoma
__Y __N Liver Disease
__Y __N Migraine Headaches
__Y __N MRSA
__Y __N Organ Transplant
__Y __N Osteoarthritis
__Y __N Osteoporosis
__Y __N Pacemaker
__Y __N Peptic Ulcer Disease
__Y __N Peripheral Vascular Disease
__Y __N Pneumonia
__Y __N Poliomyelitis
__Y __N Psoriasis
__Y __N Psychiatric Disorder
__Y __N Pulmonary Embolism (blood clot lung)
__Y __N Rheumatoid Disease
__Y __N Seizure Disorder
__Y __N Sleep Apnea
__Y __N Stroke or Mini Stroke (TIA)
__Y __N Tuberculosis
__Y __N COPD
__Y __N Skin Disease _____________

Please list any other conditions not mentioned above: ____

Do you or anyone in your family have malignant hyperthermia? ___Y ___N

OVER →

David Bub, MD, PC, FACS, FASCRS

REVIEW OF SYSTEMS: Do you have or have you had any of the following?

HEAD/EARS/EYES
__Y __N Cataracts
__Y __N Recent change in vision
__Y __N Head injury
__Y __N Ringing in the ears
__Y __N Hearing loss
__Y __N Hearing aid
__Y __N Other:_____________

NOSE/SINUSES
__Y __N Hay fever/seasonal allergies
__Y __N Frequent nose bleeds
__Y __N Other:_____________

SKIN
__Y __N Skin cancer
__Y __N Itching
__Y __N Wound healing problems
__Y __N Other:_____________

MOUTH/THROAT
__Y __N Bleeding mouth/gums
__Y __N Difficulty swallowing
__Y __N Dentures
__Y __N Other:_____________

CARDIAC
__Y __N Frequent chest pains
__Y __N Palpitations
__Y __N Infection of the heart
__Y __N Other:_____________

PULMONARY
__Y __N Shortness of breath
__Y __N Cough up blood
__Y __N Frequent coughing
__Y __N Wheezing
__Y __N Other:_____________

OB/GYN
__Y __N History of venereal disease
__Y __N Chance of pregnancy now
__Y __N Pregnancies # ______ Births # ______
__Y __N Last menstrual period: ____________

BREAST
__Y __N Cancer
__Y __N Pain
__Y __N Massess/Lumps
__Y __N Mammogram? Date: ___________.

GASTROINTESTINAL
__Y __N Abdominal pain – how long? __________
__Y __N Rectal Bleeding
__Y __N Change in bowel habits
__Y __N Constipation
__Y __N Diarrhea
__Y __N Hemorrhoids
__Y __N Rectal/anal pain, itching, burning
__Y __N Nausea/vomiting
__Y __N Change in appetite

UROLOGIC
__Y __N Increased frequency
__Y __N Dribbling
__Y __N Blood in urine
__Y __N Kidney stones
__Y __N Get up at night - how many times? ________
__Y __N Other:_____________

MUSCULOSKELETAL
__Y __N Joint pain
__Y __N Joint swelling
__Y __N Muscle disorder or problem
__Y __N Other:_____________

NEUROLOGIC
__Y __N Seizure disorder
__Y __N Fainting
__Y __N Numbness in arms or legs
__Y __N Paralysis

VASCULAR
__Y __N Aneurysm
__Y __N History of blood clots
__Y __N Other:_____________

ENDOCRINE
__Y __N Kidney dialysis
__Y __N Diabetes

IMMUNE
__Y __N Blood transfusion
__Y __N Immunosuppression

SURGERY
__Y __N Problems with anesthesia
What? ________________
__Y __N Prolonged bleeding when cut
__Y __N Latex Allergy

OVER →

David Bub, MD, PC, FACS, FASCRS

PAST SURGICAL HISTORY: List any operations you had with approximate date and/or age of surgery.

	Date/Age		Date/Age
__Y __N Appendectomy	______________________	__Y __N Cholecystectomy/gallbladder	____________________
__Y __N Hysterectomy	______________________	__Y __N Wisdom teeth extraction	________________________
__Y __N Hernia Repair	_________________________	__Y __N Tonsils/Adenoids	______________________________
__Y __N C-section	___________________________	__Y __N Prostate	_____________________________________
__Y __N Tubal Ligation	________________________	__Y __N Rectal surgery	________________________________

Please list any additional surgeries:

Operation: Date:

____
____
____
____
____

SOCIAL HISTORY:

Tobacco Use:

_____Never used _______Current User _______Former User (when did you quit:______________)

If current user: _____ cigarettes _____cigars _____ smokeless tobacco

How much per day:___________

How many years:_____________

Alcohol Use:

______Never used ______Current User ______Former User

If current user:

- _____ # of beer per day
- _____ # of wine/liquor servings per day
- _____ few times a year only
- _____ socially – weekly/weekends
- _____ alcoholism/abuse

FAMILY HISTORY:

Does anyone in your family (blood relatives) have:

_____Y_____N Colon or Rectal cancer – who? ____

_____Y_____N Colon polyps – who? ____

Please list any family members (parents, grandparents, siblings, children, aunts, uncles, cousins) with these conditions:

___ Diverticulitis ____________________________	___ Heart Disease __________________________________
___ Crohn's Disease __________________________	___ Diabetes ______________________________________
___ Ulcerative colitis _________________________	___ Asthma _______________________________________
___ Stroke __________________________________	___ High Blood Pressure _____________________________

Cancers:

___ Breast __________________________________	___ Prostate ______________________________________
___ Uterine _________________________________	___ Lung ____
___ Ovarian _________________________________	___ Liver ____
___ Stomach ________________________________	___ Other: ____