# WYOMING SURGICAL ASSOCIATES, P.C.

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## PRE-OPERATIVE PATIENT INFORMATION

Name: _____ Date: _____ Age: _____

Chief Complaint (symptoms): _____

_____

HISTORY OF PRESENT ILLNESS:

1. How long have you had this problem? _____
2. What makes your problem worse? _____
3. What makes your problem better? _____

REVIEW OF SYSTEMS:

**Circle** any problems that you have experienced recently or for prolonged periods in the past:

| | | | | | |
|---|---|---|---|---|---|
| **General:** | **W**eight loss | **W**eight gain | **W**eakness | **F**ever | **C**hills | **N**ight sweats |
| **Skin:** | **R**ash | **N**on-healing wounds | | | |
| **Eyes:** | **B**lurred vision | **L**oss of vision | **G**laucoma | | |
| **Ears:** | **D**eafness | **R**inging | **D**ischarge | **P**ain | |
| **Nose:** | **B**leeding | **D**ischarge | **O**bstruction | | |
| **Mouth:** | **B**leeding gums | **S**ore areas | **O**pen wounds | | |
| **Throat:** | **R**ecent sore throat | **D**ifficulty swallowing | **H**oarseness | **T**onsillitis | |
| **Neck:** | **P**ain | **S**tiffness | | | |
| **Breasts:** | **D**ischarge | **L**umps | **P**ain | **B**leeding | |
| **Lungs:** | **C**ough | **S**putum change | **C**oughing of blood | **S**hortness of breath | |
| **Heart:** | **P**ain in chest | **S**welling of legs | **H**istory of Rheumatic Fever | | |
| | **F**luttering of heart | **H**eart murmur | | | |
| **Vascular:** | **P**ain or cramps in legs after walking | | **V**aricose veins | **D**VT (Blood Clot) | |
| **Gastrointestinal:** | **N**ausea Vomiting | **V**omiting of blood | **H**eartburn | | |
| | **B**lack stools | **D**ark urine | **H**ernia | | |
| **Urinary tract:** | **P**ain on urination | **D**ribbling | **L**oss of urine | **B**lood in urine | |
| **Musculoskeletal:** | **B**roken bones | **A**rthritis | **S**tiff joints | **M**uscle weakness | **S**lurred speech |
| **Neurological:** | **S**eizures | **N**umbness | **P**aralysis | **H**eadache | |
| **Psychiatric problems:** | **D**epression | **N**ervousness | **A**ltered sleep (more or less) | **C**hange in appetite | |

PAST MEDICAL HISTORY: Diabetes? Yes No High Blood Pressure? Yes No

Heart Disease (including heart attack, angioplasty, coronary bypass surgery)? Yes No

Any other medical or health problems? _____

ALLERGIES TO FOOD AND OR MEDICATIONS:_____

_____

MEDICATIONS:

List present medications being taken including dosage and how often it is taken). Please list over the counter vitamins and herbal medications taken as well.

| DRUG | MGS. | HOW TAKEN | DRUG | MGS. | HOW TAKEN |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

PAST SURGERIES: _____

SOCIAL HISTORY: **M**arried **S**ingle **D**ivorced **W**idowed

Number of children?_____ Type of employment?_____

Habits? **S**moke **C**hewing Tobacco **A**lcohol **D**rug Use **E**xercise

FAMILY MEDICAL HISTORY:

Mother? **L**iving **D**eceased If deceased, cause of death?_____

Father? **L**iving **D**eceased If deceased, cause of death?_____

History of any of the following in family? **H**eart Disease **D**iabetes **L**ung Disease

**C**ancer ( Breast Colon Other )

Often times, it is necessary for **us to contact you** prior to your surgery, or right after it. Please list the **name, address and phone number** of where you will be staying from the time of this pre-operative visit until your first post-op visit.

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