# Central New York Surgical Physicians, P.C.

Date: ____________________

## PRE-EXAMINATION INFORMATION

Referring Physician ____________________

Primary Care Physician ____________________

Birthdate ____________________

Name ____________________ Age ________

Address ____________________ City ____________ State ______ Zip ______

Birthplace ____________________ Phone: (work) ____________ (home) ____________

Occupation ____________________

What is your problem? How don't you feel well? ____________________

____________________

____________________

____________________

Have you ever been diagnosed with Tuberculosis? Yes No

Any allergy to Latex? Yes No

Have you ever had a Positive P.P.D.? Yes No

If Yes, When ____________________

Do you have a bleeding disorder? Yes No

If Yes, What Type? ____________________

### FAMILY HISTORY

| | Age | If living Health | Age at death | If deceased Cause |
|---|---|---|---|---|
| **Father** | | | | |
| **Mother** | | | | |
| **Brothers or Sisters** | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Husband or Wife** | | | | |
| **Children** | | | | |
| | | | | |

Have you had any operations?

| Type | Year | Hospital | Surgeon |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you had any serious injuries?

____________________

Have you ever been a patient in a hospital?

| Reason | Year | Hospital | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

(over)

Do you have any allergies (e.g. hay fever or to medicines) ____________________

____________________

When was you last tetanus shot? ____________________

Height ____________ What is your weight ____________________

How much has it changed in the past two years? ____________________

Do you sleep well? __________ How many hours? ____________________

Do you smoke? __________ What and how much ____________________

Do you drink alcoholic beverages? __________ What and how much ____________________

**Do you have? (circle):**

| | | |
|---|---|---|
| Diabetes | Lung Disease | Vomiting |
| Thyroid disease | Shortness of breath | Loss of appetite |
| Hoarseness | Pain or pressure in chest | Intolerance to certain foods |
| Swollen Glands | Palpitation (awareness of heart beat) | Abdominal pain |
| Chronic cough | Swelling of the ankles | Change in bowel movements |
| Phlegm or sputum | Discomfort in legs when walking | Diarrhea |
| Visual problems | Heart trouble | Constipation |
| Hearing difficulties | High blood pressure | Bloody or black bowel movements |
| Coughing up blood | Indigestion | Pain in rectum |
| Wheezing | Nausea | Gall bladder trouble |
| Kidney or bladder trouble | Difficulty walking or standing | Arthritis |

Present medication being used: ____________________

____________________

____________________

____________________

____________________

Recent X-rays done: ____________________

____________________

Where? ____________________

**FOR WOMEN ONLY:**

Menstruation History: Age at onset ____________ Length of cycle (from start to start) ____________

Usual duration ____________________

Are periods regular? ____________________

Heavy ____________, Medium ____________, or Light ____________

Date of last period ____________________

**Pregnancies:**

How many pregnancies? ____________________

How many miscarriages? ____________________

Any stillbirths? ____________________

Any Cesarean sections? ____________________

Any complications? ____________________