McKENZIE SURGICAL GROUP, P.C.

Steven L. Wilhite, M.D.

PATIENT MEDICAL HISTORY FORM

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Reason for your visit/consultation: _____

List past surgeries that you have had: _____

_____

Besides the above, list reasons that you have been hospitalized: _____

_____

List health problems for which you regularly see your physician: (Example: Headache, depression, etc.) _____

_____

Do you smoke? NO YES If yes, _____ packs per day, for _____ years

Do you drink alcohol? NO YES If yes, _____ drinks per (day / week / month)

Do you use street drugs? NO YES Do you use Marijuana? NO YES

ALLERGIES: Please list any medication allergies and reactions. (Example: Vicodin/Causes nausea and vomiting)

Please mark with an "X" if you take any of the following:

___Coumadin ___Warfarin ___Plavix/Pletal ___Aspirin/Excedrin ___Ibuprofen/Advil/Aleve/Naprosyn ___Alka-Seltzer

MEDICATIONS: Please list all medications that you take and dosages for each. (Example: Flexeril/10 mg/1 daily)

FAMILY HISTORY: Do/did any of your family members have health problems with the following & at what age?

Heart Disease		Gallbladder	
Blood Pressure		Cancers, type?	
Blood Clots		Hepatitis	
Aneurysms		Diabetes	

Please See Other Side

MARK WITH AN "X" ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE NOW or HAVE HAD IN THE PAST

Review of Systems

GENERAL:
___Persistent fever
___Chills/cold intolerance
___Lack of appetite
___Diabetes
___Anemia
___Thyroid disease
___Other:_____

SKIN:
___Ulcers
___Easy bruising
___Change in moles or spots
___Rashes or hives
___Eczema or Psoriasis
___Other:_____

EYES:
___Eye pain
___Blind spots in one eye
___Change of vision
___Eye infection
___Other:_____

EARS/NOSE/THROAT:
___Earache
___Hearing loss
___Ear infection or drainage
___Ringing in the ears
___Bleeding from the ears
___Swollen glands/lumps
___Sinus trouble

LUNGS:
___Shortness of breath
___Sleep Apnea
___Persistent cough

LUNGS: (CONT.)
___Wheezing
___Coughing up blood
___Coughing up phlegm
___Difficulty breathing
___Tuberculosis
___Abnormal chest x-ray
___Bronchitis/pneumonia

GASTROINTESTINAL:
___Excessive burping
___Bloody or black stools
___Change in bowel habits
___Difficulty swallowing
___Excessive gas
___Heartburn or reflux
___Gastritis
___Jaundice
___Diverticulitis
___Hemorrhoids
___Diarrhea
___Fecal incontinence
___Nausea, vomiting
___Abdominal pain
___Other:_____

URINARY:
___Change in stream of flow
___Difficulty urinating
___Blood in urine
___Increased/decreased frequency
___Pain/burning with urination
___Incontinence
___Kidney stones

URINARY: (CONT.)
___Urinary tract infections
___Other:_____

BONES AND JOINTS:
___Back or neck pain
___Painful or stiff joints
___Gout
___Tendonitis
___Bursitis
___Other:_____

MOOD/MENTAL HEALTH:
___Depressed, anxious, fearful
___Irritable or angry
___Insomnia
___Fatigue
___Concentration/memory loss
___Other:_____

NEUROLOGIC:
___Dizziness
___Fainting spells
___Headaches
___Migraine headaches
___Other:_____

HEART/VASCULAR:
___Discoloration of hands/feet
___Chest pain
___Irregular heart beat
___Racing/fluttering heart
___Previous heart attack
___Previous heart catheterization
___Stroke or mini-stroke
___Varicose veins

HEART/VASCULAR: (CONT.)
___Abdominal aortic aneurysm
___Muscle cramps
___Muscle weakness
___Pain in legs
___Pain with walking
___Swelling of legs and/or feet
___Numbness/tingling-legs/feet
___Unable to walk stairs
___Other:_____

MEN:
___Impotence

WOMEN:
___Using birth control
___Using hormone replacement
Number of children_____
Number of pregnancies _____
Last pap smear date_____
Last Mammogram_____
Last period date_____

BREASTS:
___Discharge or bleeding
___Lumps
___Pain
___Previous biopsy done?
___Other:_____

STD's:
___Hepatitis
___HIV
___Gonorrhea
___Herpes
___Chlamydia
___Human Papillomavirus

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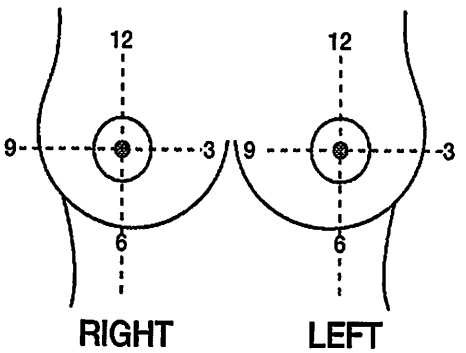
THIS SECTION TO BE COMPLETED BY THE PHYSICIAN

Breast Exam



Vascular Exam

	PULSES		BRUITS		DOPPLER PRESSURE		
	Right	Left	Right	Left		Right	Left
Carotid					Brachial		
Brachial					D.P.		
Radial					P.T.		
Femoral					A		
Popliteal							
D.P.							
P.T.							

Notes: