Chelsea Surgical Care

Completed by patient or_____ Today's Date_____

Name: _____Date of Birth_____ Age: _____
Reason for visit:_____
Primary Care Physician: _____ Referring Physician:_____

Medications: (Dose and how often you take them): _____
_____
_____

***ALLERGIES*: (medication/food) _____**

***LATEX ALLERGIES*: _____ YES _____NO**

Medical History: Please check all that apply;

Illness	Date	Illness	Date	Illness	Date
Breast Lump	____	Asthma	____	Thyroid Disease	____
Breast Cancer	____	Peptic Ulcer Disease	____	Prostate Disease	____
Lung Cancer	____	Lung Problem	____	Colon Cancer	____
Heart Attack	____	High Blood Pressure	____	Lymphoma/ Leukemia	____
Heart Problems	____	Coronary Artery Disease	__	Sleep Apnea	____
Kidneys Disease	____	HIV	____	Diabetes	____
Stroke	____	Diverticulitis	____	Arthritis	____
DVT	____	Lyme disease	____	Cholesterol	____
Pace Maker/ Defibrillator	____	Other	_____		

Past Surgeries:

Surgery	Date	Surgery	Date	Surgery	Date
Gallbladder	____	Breast	____	Abdomen Aortic Aneurysm	____
Dialysis Access	____	Hernia	____	Tubal Ligation	____
Vein Problems	____	Carotid	____	Hysterectomy	____
Hemorrhoids	____	Intestinal	____	Colonscopy	____
Peripheral Artery	____	Thyroid	____	Other	_____

***FamilyIllnesses*:_____**
_____

***Social History*:**
Do You Smoke? Yes/No (circle), if yes how often _____
Do You Drink Alcohol? Yes/No (circle), if yes how often_____
Do You Use Drugs? Yes/No (circle), if yes how often_____
Do You Drink Caffeine Yes/No (circle), if yes number of cups coffee/tea per day_____
Do You have a Living Will? Yes/No (circle), if no, would you like one? Yes/No(circle)

Chelsea Clinic may release my Protected Health Information to:
Name:_____ Your Initials ____
Name:_____ Your Initials ____
Name:_____ Your Initials ____

Complete Back→

Name_____**Age**_____**Today's Date**_____
Birthdate_____**Wt**_____**Ht**_____**Primary Care Physician**_____
Reason for Visit_____**Referring Physician**_____

SYMPTOMS/CONDITIONS (Check symptoms or conditions that pertain to you.)

General
- ○ AIDS ○ HIV
- ○ Anemia
- ○ Chills
- ○ Dizziness
- ○ Fainting
- ○ Fatigue
- ○ Fever
- ○ Headache
- ○ Sweats
- ○ Weight loss/gain

Eyes
- ○ Blurred vision
- ○ Blindness
- ○ Cataract
- ○ Glaucoma
- ○ Temporary vision loss

Ear/Nose/Throat
- ○ Bleeding gums
- ○ Difficulty swallowing
- ○ Facial droop
- ○ Goiter
- ○ Hearing loss
- ○ Hoarseness
- ○ Nosebleeds
- ○ Pain
- ○ Sinusitis
- ○ Slurred speech

Neurologic
- ○ Epilepsy
- ○ Multiple sclerosis
- ○ Stroke/TIA
- ○ Weakness

Respiratory
- ○ Asthma
- ○ Blood in sputum
- ○ Bronchitis
- ○ Difficulty breathing
- ○ Emphysema
- ○ Lung cancer
- ○ Persistent cough
- ○ Pneumonia
- ○ Shortness of breath
- ○ Tuberculosis
- ○ Wheezing

Cardiovascular
- ○ Chest pain
- ○ Heart attack
- ○ High blood pressure
- ○ High cholesterol
- ○ Irregular/Rapid heart beat
- ○ Pacemaker/defibrillator
- ○ Poor circulation
- ○ Leg/foot pain
- ○ Leg/foot swelling
- ○ Varicose veins

Musculoskeletal
- ○ Arm/Leg weakness
- ○ Gout
- ○ Fractures
- ○ Arthritis
- ○ Hernia

Endocrine
- ○ Diabetes
- ○ Thyroid disease
- ○ Parathyroid disease

Gastrointestinal
- ○ Abdominal pain
- ○ Appendicitis
- ○ Appetite poor
- ○ Belching
- ○ Bloating
- ○ Bowel changes
- ○ Colon cancer
- ○ Constipation
- ○ Diarrhea
- ○ Excessive gas
- ○ Hemorrhoids
- ○ Hepatitis
- ○ Indigestion
- ○ Jaundice
- ○ Liver disease
- ○ Nausea
- ○ Rectal bleeding
- ○ Reflux
- ○ Vomiting
- ○ Vomiting blood

Psychiatric
- ○ Anxiety
- ○ Chemical dependence
- ○ Depression
- ○ Psychiatric care

Dermatology
- ○ New/changing mole
- ○ Rash
- ○ Itching
- ○ Melanoma
- ○ Skin cancer

Breast
- ○ Pain
- ○ Nipple discharge
- ○ Mass/lump
- ○ Abnormal mammogram
- ○ Family history cancer
- ○ History of cancer
- ○ Prior biopsies
- ○ Prior mammogram

Genitourinary
- ○ Abnormal pap smear
- ○ Blood in urine
- ○ Impotence
- ○ Kidney disease
- ○ Kidney stones
- ○ Painful urination
- ○ Prostate disease
- ○ Urinary incontinence
- ○ Urinary tract infection
- ○ Venereal disease

Obstertrics (women only)
- ○ Age 1st menstruation__
- ○ Age 1st child birth____
- ○ Number births ____
- ○ Are you Pregnant?____

Hematologic
- ○ Bleeding disorder
- ○ Blood clots
- ○ Blood transfusion
- ○ Easy bruising
- ○ Hemophilia
- ○ Lymphoma
- ○ Leukemia

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