Fullerton Surgery Center

Affix Patient Label Here

Initial Patient History

Please indicate whether or not you have experienced any of the following.

PAST & PRESENT MEDICAL SURGICAL HISTORY

	No	Yes	Comments		No	Yes	Comments
Asthma	☐	☐		Genital Warts	☐	☐	
Tuberculosis	☐	☐		Thyroid Problem	☐	☐	
Heart Disease	☐	☐		Cyst/Skin Growth	☐	☐	
Rheumatic Fever	☐	☐		Kidney Disease	☐	☐	
Chest Pains	☐	☐		Bladder Infection	☐	☐	
Shortness of Breath	☐	☐		Liver Disease/ Hepatitis	☐	☐	
Cigarette Smoling	☐	☐		Diabetes	☐	☐	
Thrombophlebitis	☐	☐		Mononucleosis	☐	☐	
Bleeding Problems	☐	☐		Swelling	☐	☐	
Stroke	☐	☐		German Measles (Rubella)	☐	☐	
High Blood Pressure	☐	☐		Depression	☐	☐	
Varicose Veins	☐	☐		Headaches	☐	☐	
Anemia	☐	☐		Blurred Vision	☐	☐	
Hemmorrhoids	☐	☐		Epilepsy (seizures)	☐	☐	
Fissure	☐	☐		Stomach/bowel problems	☐	☐	
High Cholesterol	☐	☐		Surgery	☐	☐	
Skin Problems	☐	☐		Sickle Cell Anemia	☐	☐	
Cancer	☐	☐		Other Major Illness	☐	☐	
Venereal Disease	☐	☐		Medicines, Drugs used	☐	☐	
Herpes	☐	☐		Foot Problems	☐	☐	
Pelvic or Menstrual Pain	☐	☐		Other_____			

ARE YOU ALLERGIC TO:

Penicillin	☐	☐	Iodine	☐	☐
Tetracycline	☐	☐	Any Kind of Food	☐	☐
Aspirin	☐	☐	Any Metals (jewelry)	☐	☐
Codeine	☐	☐	Latex	☐	☐
Sulfa	☐	☐	Other Allergies_____		

FAMILY HISTORY

Are you adopted? ☐ ☐

Have your grandparents, parents, brothers or sisters ever had:

Cancer	☐	☐	**Sickle Cell Disease**	☐	☐
Diabetes	☐	☐	**Stroke/ Blood Clots**	☐	☐
Heart Attack	☐	☐	High Cholesterol	☐	☐
High Blood Pressure	☐	☐	Others_____		

FEMALE ISSUES

Breast Pain	☐	☐	Breast Discomfort	☐	☐
Breast Discharge	☐	☐	Breast Bleeding	☐	☐
Breast Lumps	☐	☐	Date of your last menstrual cycle.		

List medications you are taking including over the counter medications, diet pills, vitamins and herbal preparations. _____

_____

Nearest Relative:

Name:_____ Address:_____

Phone #: _____ Today's Date:_____

Patient Signature:_____ Witness:_____