# SurgOne, P.C.

David J. Lundy, M.D.
2352 Meadows Blvd., #220
Castle Rock, CO 80109

## Medical History/Review Of Systems

Today's Date: _____

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Requesting/Referring Physician _____ Primary Physician _____

Reason for Visit (Chief Complaint): _____

History of the Present Illness: _____

| List all Significant **Medical Problems** | Please list all **Medications** and their doses: |
|---|---|
| 1 | 1 Dose |
| 2 | 2 Dose |
| 3 | 3 Dose |
| 4 | 4 Dose |
| 5 | 5 Dose |
| 6 | 6 Does |
| 7 | 7 Dose |
| 8 | 8 Dose |

List ALL **past surgeries** you have had and approx. date

1

2

3

4

**Reproductive History** (Please indicate number or Pregnancies and Births)

Pregnancies _____ Births _____ Lost Pregnancies _____

**Allergies** (Please list) are you allergic to any medicines, tape, latex, etc.

**SOCIAL HISTORY**

Do you smoke? _____ (if so how much per day?) _____ If you have smoked, when did you quit? _____

Do you drink alchohol? _____ (if so how many drinks per day?) _____

Do you use any non-prescribed drugs? _____ (if so, what?) _____

Are you on any type of special diet? Please describe _____

What is/was your occupation? _____

**FAMILY HISTORY** Please indicate if any family member (including Grandparents, Parents, Siblings) had/does have the following:

Gall bladder problems _____ Reaction to Anesthesia _____

Bleeding or clotting problems _____ Breast Cancer _____

Heart Attacks _____ Ovarian Cancer _____

Diabetes _____ Colon Cancer _____

Blood Pressure Problems _____ Any other Cancers _____

Anything else your physician should know about your health or your family's health?

# MEDICAL HISTORY/REVIEW OF SYSTEMS

Have you been diagnosed with and/or are you currently having (in the last 6 months) any of the following symptoms?

## Neurologic/Head, Eyes, Ears, Nose Throat

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Numbness/tingling | | | |
| Loss of strength | | | |
| Stroke (CVA/TIA) | | | |
| Headaches-type | | | |
| MS | | | |
| Ear problems | | | |
| Eye problems | | | |
| Nose/Sinus problems | | | |
| Throat problems | | | |

## Musculoskeletal / Skin

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Back/Neck/Joint problems | | | |
| Loss of sensation | | | |
| Rash / Skin breakdown | | | |
| Arthritis (type) | | | |
| Fractures | | | |
| Osteoporosis | | | |
| Joint Replacement | | | |

## Endocrine

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Tired / Sluggish | | | |
| Excessive thirst | | | |
| Diabetes | | | |
| Thyroid problems | | | |

## Respiratory

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Wheezing | | | |
| Shortness of breath | | | |
| Productive/bloody cough | | | |
| Bronchitis | | | |
| Pneumonia | | | |
| Pulmonary embolism | | | |
| Turberculosis | | | |

## Cardiac

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Heart murmur | | | |
| Chest pain (Angina) | | | |
| Palpations / heart racing | | | |
| Congestive heart failure | | | |
| Heart attack | | | |
| High blood pressure | | | |
| Pacemaker | | | |
| Artificial Heart Valve | | | |
| Rheumatic fever | | | |

## Communicable Diseases

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Malaria | | | |
| AIDS / HIV | | | |
| Hepatitis A / B / C | | | |
| Sexual trans disease | | | |
| Tuberculosis | | | |

## Digestive (Stomach / Bowel)

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Abdominal pain | | | |
| Nausea / Vomiting | | | |
| Constipation/Diarrhea | | | |
| Colitis | | | |
| Diverticulitis | | | |
| Hiatal Hernia | | | |
| Reflux Esophagitis | | | |
| Irritable bowel | | | |
| Ulcers | | | |
| Pancreatitis | | | |
| Rectal bleeding or pain | | | |
| Change in bowel habits | | | |
| Cirrhosis | | | |
| Jaundice | | | |
| Hemorrhoids | | | |
| Gallstones | | | |

## Genitourinary / GYN

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Kidney problems | | | |
| Bladder infections | | | |
| Kidney failure | | | |
| Prostate infections | | | |
| Uterine problems | | | |
| Ovarian problems | | | |

## Breast

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Nipple discharge | | | |
| Lumps | | | |
| Pain | | | |
| Prior Surgery | | | |

## Blood / Immune System

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Swollen lymph glands | | | |
| Anemia | | | |
| DVT / Phlebitis / Clots | | | |
| Lupus | | | |

## Cancer

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Type | | | |
| Treatment | | | |
| Location | | | |

## Psychologic (Emotional)

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Nervousness | | | |
| Anxiety | | | |
| Depression | | | |
| Other | | | |

## Constitutional

| Do you have the following | NO | YES | If yes please indicate below |
|---|---|---|---|
| Fever | | | |
| Chills | | | |
| Weight loss | | | |
| Night Sweats | | | |