Fall General Surgery, LLC

NEW PATIENT HISTORY FORM *(Page 1 of 2)*

Today's Date: _____

Name (Please Print): _____ **DOB:** _____

MEDICAL HISTORY

Have you ever been treated for any of the following?

- ☐ Acid Reflux/Stomach Ulcers
- ☐ Anesthesia Reaction
- ☐ Anxiety/Depression
- ☐ Blood Clots
- ☐ Bleeding Tendency
- ☐ Cancer
- ☐ Diabetes
- ☐ Gallbladder Problems
- ☐ Heart Problems
- ☐ Hernia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Immune System Problem
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung/Breathing Problems
- ☐ Pancreatitis
- ☐ Seizures
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Varicose Vein Problems
- ☐ Vascular (Blood Vessel) Disease
- ☐ Other:_____

_____

SURGICAL HISTORY

- ☐ Appendectomy
- ☐ Bowel Surgery
- ☐ Hernia Repair
- ☐ Gallbladder Removal
- ☐ Skin Cancer Removal
- ☐ Breast Cancer Surgery
- ☐ Heart Surgery
- ☐ Lung Surgery
- ☐ Cesarean Section
- ☐ Hysterectomy or other Gynecologic Surgery
- ☐ Tonsillectomy
- ☐ Vein Surgery
- ☐ Colonoscopy
- ☐ EGD
- ☐ Other: _____

_____

Please provide details if you checked any boxes above:_____

_____

_____

_____

ALLERGIES: _____

_____

MEDICATIONS *(Please also include Herbs, Supplements, and Over the Counter)*

____ See Attached List Current Pharmacy: _____

_____

_____

_____

Continue Medications or History on back, with Family History --→

Patient Signature: _____

Please check the family member (i.e., father, mother, sibling, etc.) in the blank space provided.

Concern	**Father:**	**Mother:**	**Sibling:**	**Other – Please List:**
Anesthesia Reaction				
Asthma				
Bleeding Tendency				
Blood Clots				
Cancer & Type				
Diabetes				
Gallbladder Problems				
Heart Problems				
Hepatitis				
Hernia				
High Blood Pressure				
Immune System Problem				
Liver Disease				
Pancreatitis				
Seizures				
Skin Problems				
Stroke				
Thyroid Disease				
Varicose Vein Problems				
Vascular (Blood Vessel) Disease				

Other Concerns: _____

_____

_____

Patient Signature: _____