General, Vascular, and Bariatric Surgery New Patient Form

Name: _____ Date of Birth: _____

Reason for Visit: _____ Today's Date: _____

Medical History

Problem (e.g. hypertension, diabetes, etc.)	Year Diagnosed

Surgical History

Surgery	Year Performed	Surgeon

Medications

Please list the medications you are taking (prescription, over the counter, and supplements). Complete the column for dosage and mark the box for how often you are taking each medication. Attach additional pages if needed.

Medication Name	Dosage	How often you are taking?			
		1x/day	2x/day	3x/day	As needed

Preferred Pharmacy: _____

Medication Allergies

Medication	Reaction

Social History

Marital Status**:** ☐ Single ☐ Married ☐ Widowed

Do you smoke? ☐ No ☐ Yes Packs per day: _____
Do you drink alcohol? ☐ No ☐ Yes Drinks per week: _____
Do you use illegal drugs? ☐ No ☐ Yes What kind? _____

Family History

Family Member	Mother	Father	Sibling
Current	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased	☐ Alive ☐ Deceased
Age			
Illness(es)			

Constitutional	☐ Fever ☐ Chills ☐ Weight Loss ☐ Fatigue ☐ Sweating ☐ Weakness
Skin	☐ Rash ☐ Itching
HENT	☐ Hearing loss ☐Tinnitus/Ringing ☐ Ear pain ☐ Ear discharge ☐ Sore throat ☐ Nosebleeds ☐Congestion ☐ Sinus Pain ☐ Stridor
Eyes	☐ Blurred vision ☐ Double vision ☐ Light sensitivity ☐ Eye pain ☐ Eye discharge ☐ Eye redness
Cardiovascular	☐ Chest pain ☐ Palpitations ☐ Orthopnea ☐ Shortness of breath ☐ Leg swelling ☐ Leg cramps ☐ Shortness of breath at night
Respiratory	☐Cough ☐ Coughing up blood ☐Sputum production ☐ Wheezing
GI	☐ Abdominal Pain ☐Blood in stool ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐Nausea ☐ Vomiting
Urinary	☐ Urgency ☐ Painful urination ☐ Frequency ☐ Hematuria ☐Flank pain
Musculoskeletal	☐ Muscle pain ☐ Neck pain ☐ Back pain ☐ Joint pain ☐ Falls
Hem/Lymph	☐ Easy bruising ☐ Environmental allergies ☐ Extreme thirst
Neurological	☐ Dizziness ☐ Headaches ☐ Loss of consciousness ☐ Tingling
Sensory Changes	☐ Speech Change ☐ Focal weakness ☐ Seizures ☐ Tremor
Psychiatric	☐ Depression ☐ Suicidal ideas ☐ Hallucinations ☐ Insomnia ☐ Substance abuse ☐ Nervous/anxious ☐ Memory loss

Pain Contract

Do you have an existing pain contract? ☐ Yes ☐ No

If yes, who is the provider that is managing your pain contract? _____

333 SE 7th Ave, Suite 5200
Phone: 503-681-4310
Fax: 503-681-1989

New Patient Preoperative Screening Form

Please check yes or no if have experienced any of these conditions in your lifetime.

	Yes	No
Heart Trouble / Heart Surgery	☐	☐
Chest Pain / Angina	☐	☐
Congestive Heart Failure	☐	☐
High Blood Pressure / Hypertension	☐	☐
Irregular Heartbeat Please Describe:	☐	☐
Rheumatic Fever	☐	☐
Pacemaker / Defibrillator	☐	☐
Coagulation Defect / Blood Clots / DVT	☐	☐
Diabetes	☐	☐
Hepatitis ☐ Type A ☐ Type B ☐ Type C Date:	☐	☐
Anemia	☐	☐
Acute / Chronic Liver Disease	☐	☐
Kidney Disease	☐	☐
Receiving Dialysis	☐	☐
Current Cancer Diagnosis	☐	☐
Currently undergoing chemotherapy or radiation?	☐	☐
Current Infection / Fever	☐	☐
Currently Pregnant If yes, due date:	☐	☐

Medications	Yes	No
Anticoagulants (i.e. Warfarin, Lovenox, etc.)	☐	☐
Steroids	☐	☐
Insulin / Hypoglycemia Agents	☐	☐
Digoxin	☐	☐

Other	Yes	No
Anticipated blood replacement (i.e. laparoscopic/open procedures, joint replacement)	☐	☐
Bowel Prep Planned Preop	☐	☐
EKG If Yes, Date: _____ Location: _____	☐	☐
Established with a cardiologist – If Yes, Name:	☐	☐