Abington Jefferson Health

125 Medical Campus Drive
Medical Arts Building
Suite 310
Lansdale, PA 19446

NORTH PENN SURGICAL ASSOCIATES
Medical History Form

Name: _____ DOB:_____ Height:_____ Weight:_____
Nature of Visit: _____
Symptoms: _____
_____
_____
When did your symptoms begin? _____
Does anything make your symptoms better or worse? YES NO
Please describe: _____
Since they began, are your symptoms: worse better same
Do you feel you understand your problem? YES NO

Medications/Dosages/Frequency:

_____
_____
_____
_____

Allergies to medications, latex or IV Dye: _____
Any previous reactions to anesthesia? _____

Blood Thinner Treatment: _____ Coumadin/Warfarin: _____ Plavix: _____ Aspirin: ___
Do you smoke? YES NO
No # of packs per day: _____/#of years smoke: _____/Quit? _____
Do you use alcohol? _____ Yes_____ No # of drinks per week _____
History of excessive alcohol use: _____
History of drug/substance abuse: _____

Prior Surgical History (list all operations):

_____
_____
_____
_____

Family Medical History: Living/Deceased, Illness/cause of death:
Mother _____ Father _____
Sisters _____ Brothers _____

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Do you have or have you ever had:

Migraines	Yes	No	Angina	Yes	No
Seizures	Yes	No	Pacemaker	Yes	No
Numbness Where? _____	Yes	No	Defibrillator	Yes	No
Stroke	Yes	No	Depression	Yes	No
TIA	Yes	No	Anxiety	Yes	No
Paralysis	Yes	No	Bipolar Disorder	Yes	No
Multiple Sclerosis	Yes	No	ADD/ADHD	Yes	No
Parkinson's disease	Yes	No	Asthma	Yes	No
Alzheimer's	Yes	No	COPD	Yes	No
Cataracts	Yes	No	Emphysema	Yes	No
Glaucoma	Yes	No	Pneumonia	Yes	No
Hearing Loss	Yes	No	Sleep Apnea	Yes	No
Macular Degeneration	Yes	No	Kidney Disease	Yes	No
High Blood Pressure	Yes	No	Kidney Failure	Yes	No
High Cholesterol	Yes	No	Dialysis	Yes	No
High Triglycerides	Yes	No	Kidney Stones	Yes	No
Coronary Artery Disease	Yes	No	Frequent Urination	Yes	No
Congestive Heart Failure	Yes	No	Inguinal Hernia Right or Left? _____	Yes	No
Heart Attack	Yes	No	Hiatal Hernia	Yes	No
Peripheral Artery Disease	Yes	No	Umbilical Hernia	Yes	No
Heart Stents	Yes	No	Enlarged Prostate	Yes	No
Heart Catheterization	Yes	No	Reflux/Heartburn	Yes	No
Atrial Fibrillation	Yes	No	Stomach Ulcers	Yes	No
Heart Murmur	Yes	No	Any Bone Fractures? Where? _____	Yes	No

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Liver Disease	Yes	No	Hepatitis	Yes	No
Arthritis	Yes	No	Liver Cirrhosis	Yes	No
Osteoporosis	Yes	No	Chronic Constipation	Yes	No
Fibromyalgia	Yes	No	Chronic Diarrhea	Yes	No
Fibrocystic Breast Disease	Yes	No	Rectal Bleeding	Yes	No
Anemia	Yes	No	Hemorrhoids	Yes	No
Bleeding Disorders	Yes	No	Diverticulitis	Yes	No
Blood Transfusion	Yes	No	Diabetes	Yes	No
Hyperthyroid	Yes	No	Herniated Discs	Yes	No
Hypothyroid	Yes	No	Spinal Stenosis	Yes	No
Back Pain	Yes	No	Neck Pain	Yes	No

Cervical or Lumbar? _____

Please list any cancers you have had: _____

_____

_____

Any other medical conditions not mentioned? _____

_____

_____