N O R T H D A L L A S S U R G I C A L S P E C I A L I S T S \cdot 3600 SHIRE BLVD, SUITE 104 \cdot RICHARDSON, TEXAS 75082 \cdot

Today's Date:/_	/			1	ist maior illne	esses or medical p	oroble	ms:	
Name:				_				··· * ·	
Birthdate://				_					
Occupation:				_					
				_	ist all operati	ons (type and dat	:e):		
What is your approxima		ignt?							
Weight?	_			-					
Reason for seeing the	docto	r today:		_					
		 			-	a colonoscopy? tions you are alle			-
						☐ lodine ☐ Late	-		-
What medical tests were	com	pleted pri	or to your visit toda					-	
		·				FAMILY	н	STOR	Υ
						No	Yes	Family Rel	ationship er, Sister, Grandparent)
				T	Pulmonary			(Father, Mother, Brothe	er, Sister, Grandparent)
PERSON	A L	. н і	STORY		Blood clots/				
Check any of the following	na voi	ı have ha	d and when:	-	Diabetes Tuberculosi	s 🚨			
oncok any or the following					Lung Disea	se 🗆			
	No	Yes	Date		Heart Disea	ise 🔲			
Pulmonary embolism					Stroke				
Blood clots/DVT					Kidney Dise High Blood	ease Pressure			
Rheumatic Fever					Cancer				
Thyroid Disease					Bleeding Te	_			
High Blood Pressure						alcohol? □			
Circulatory Problems					If yes, how	/ often?		How long?	
Heart Disease					Have you e	ver			
Heart Murmur					used tobac Do you curr	cco?			
Hepatitis					Do you curr	rently co?			
Chemotherapy					1		_	How long?	
Excess Bleeding						unt			
Diverticulosis					if you nave	quit, how long ag	0?		
Pancreatitis									
Tuberculosis					M	EDICA.	ΤΙΟ	ONINF	0
Emphysema						NAME		STRENGTH	DOSAGE
Jaundice						☐ Blood thinner		STRENGTH	DOSAGE
Arthritis						☐ Diet pills			<u> </u>
Cirrhosis									
Cancer									
Colitis									
Diabetes					Prescribed				
Ulcer									
Epilepsy									
Anemia									
Stroke									
Asthma									
Hernia									
Glaucoma					Over-the				
				1	Counter				

Reviewed: _ (rev. 08-13-2017)

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Please check if you have had any of these symptoms recently

Recent change in weight	CONSTITUTIONAL	NO	YES	MUSCULOSKELETAL	NO	YES
Gained:	Recent change in weight			Stiff or painful joints		
Lost:	How many pounds?			Muscle pain		
Lost:	Gained:					
Since when? Coughing up blood Coughing up				RESPIRATORY		
Fever				Shortness of breath		
Fatigue	Loss of appetite			Coughing		
Bronchitis more than once per month	Fever			Coughing up blood		
HEAD Frequent headaches Seizures Head injury Hear palpitations Have you had a stress test? Frouble with vision Hear palpitations Hoarse voice BARS, NOSE, AND THROAT Trouble hearing Hoarse voice GASTROINTESTINAL Heartburn Feel bloated after eating Have difficulty swallowing Nausea and vomiting Have vomited blood Constipation Diarrhea Black stools Hemorrhoids Rectal bleeding Have pain in stomach Arter eating? Have pain in stomach Have pain elsewhere In abdomen Blood in urine CARDIOVASCULAR Chest pain, or tightness Difficulty in breathing Heat pain, or tightness Difficulty in breathing Difficulty	Fatigue			Wheezing		
Frequent headaches	Night sweats			Bronchitis more than once		
Frequent headaches Seizures Head injury (If yes, when?/) EYES Trouble with vision Wear corrective lenses EARS, NOSE, AND THROAT Trouble hearing Hoarse voice GASTROINTESTINAL Heartburn Feel bloated after eating Have uomited blood Constipation Black stools Black stools Black stools Black stools Black stools Black stools Black pain in stomach After eating? Have pain elsewhere In abdomen Blood in urine GENITO-URINARY Burning with urination Blood in urine Chest pain as tress test? Chest pain or tightness Chest pain plifting Heart palpitations Heart palpitations Heart palpitations Heart palpitations Chest pain or tightness Heart palpitations Have pain coloration of your skin Any lums proticed: Under your arms? Darries Darries				per month		
Seizures Head injury (If yes, when? /) (If yes, when? /) EYES Trouble with vision Wear corrective lenses EARS, NOSE, AND THROAT Trouble hearing Hoarse voice Heart palyitations Have you had a stress test? (If yes, when? /) Physician/Cardiologist name: SKIN Changes in coloration of your skin Any lumps noticed: Under your arms? Heartburn Heart palyitation Heart palyitations Have difficulty with vision Under your arms? Have difficulty swallowing Nausea and vomiting Have womited blood Constipation Diarrhea Black stools Hemorrhoids Rectal bleeding Have pain in stomach After eating? Have pain in stomach After eating? Have pain elsewhere In abdomen MOOD Depressed? Anxious? Trouble sleeping? SLEEP Sleep Apnea (If so, do you use CPAP?) Date of last sleep study?	· · - · · -					
Head injury (If yes, when? / /) EYES Trouble with vision					_	_
Heart palpitations		_	-	•		
EYES Trouble with vision Wear corrective lenses EARS, NOSE, AND THROAT Trouble hearing Hoarse voice GASTROINTESTINAL Heartbum Have difficulty swallowing Nausea and vomiting Constitution Have vomited blood Constitution Diarrhea Black stools Hemorrhoids Rectal bleeding Have pain in stomach After eating? Have pain in stomach Blood in urine Have you had a stress test? (If yes, when?		-		•		_
Trouble with vision	(If yes, when?//)		The state of the s		
Trouble with vision Wear corrective lenses EARS, NOSE, AND THROAT Trouble hearing Hoarse voice GASTROINTESTINAL Heartburn Feel bloated after eating Have difficulty swallowing Diarrhea Black stools Black stools Heartorhoids Rectal bleeding Have pain in stomach After eating? Have pain elsewhere In abdomen GENITO-URINARY Burning with urination Blood in urine AKIN Changes in coloration of your skin Any lumps noticed: Under your arms? Groin area? Under your arms? Changes in coloration of your skin Any lumps noticed: NEUROLOGIC Conquisions Any lumps noticed: Under your arms? Oron area? In Any lumps noticed: Under your arms? In Any lumps noticed: In					, U	ш
BARS, NOSE, AND THROAT Trouble hearing Hoarse voice GASTROINTESTINAL Heartburn Feel bloated after eating Have difficulty swallowing Have vomited blood Constipation Diarrhea Black stools Hemorrhoids Rectal bleeding Have pain in stomach After eating? Have pain elsewhere In abdomen Blood in urine BARS, NOSE, AND THROAT Trouble hearing Changes in coloration of your skin Any lumps noticed: Under your arms? Under your arms? Oroin area? Oroin area? OROIN ANY Under your arms? OROIN ANY OROIN ANY SPEAK SKIN Changes in coloration of your skin OROIN ANY Under your arms? OROIN ANY OR					_)	
EARS, NOSE, AND THROAT Trouble hearing				Physician/Cardiologist name:		
Trouble hearing	Wear corrective lenses					
Trouble hearing Hoarse voice	EARS, NOSE, AND THROAT			SKIN		
Hoarse voice	Trouble hearing					
Any lumps noticed: Under your arms?	Hoarse voice			your skin		
Under your arms?						
Feel bloated after eating						
Have difficulty swallowing Nausea and vomiting Neurologic Convulsions Constipation Diarrhea D				Groin area?		
Nausea and vomiting Have vomited blood Constipation Diarrhea Diarr				Breast?		
Have vomited blood				NITUTO! 0010		
Constipation	_					
Diarrhea						_
Black stools						_
Hemorrhoids						
Rectal bleeding						
Have pain in stomach After eating? Have pain elsewhere In abdomen GENITO-URINARY Burning with urination Blood in urine MOOD Depressed? Anxious? In abdomen SLEEP Sleep Apnea (If so, do you use CPAP?) Date of last sleep study? MOOD Depressed? Anxious? In abdomen GENITO-URINARY Burning with urination Blood in urine Date of last sleep study? MOOD Depressed? In abdomen In abdome						
After eating? Have pain elsewhere In abdomen GENITO-URINARY Burning with urination Blood in urine Depressed? Anxious? Trouble sleeping? SLEEP Sleep Apnea (If so, do you use CPAP?) Date of last sleep study? Depressed? In abdomen In apprenticular in the indicator in the ind	_			toes, iimbs?	ш	ш
Have pain elsewhere In abdomen GENITO-URINARY Burning with urination Blood in urine SLEEP Sleep Apnea (If so, do you use CPAP?) Date of last sleep study? Date of last sleep study?	-			MOOD		
In abdomen	_			Depressed?		
GENITO-URINARY Burning with urination Blood in urine SLEEP (If so, do you use CPAP?) Date of last sleep study? J	•			Anxious?		
Burning with urination Blood in urine Sleep Apnea (If so, do you use CPAP?) Date of last sleep study? / /	In abdomen			Trouble sleeping?		
Blood in urine	GENITO-URINARY			_		
Date of last sleep study?//	Burning with urination					_
	Blood in urine			· · · · · · · · · · · · · · · · · · ·		
Reviewed: (rev. 08-13-2017) Patient: Date: / /				Date of last sleep study? _	/	/
Reviewed: (rev. 08-13-2017) Patient: Date: / /						
	Reviewed: (rev	08-13-2017)	Patien	t: D:	ate: /	/