Bruce French, MD   Sanjay Mehta, MD   Kevin Pugh, MD
Joaquin Castaneda, MD   Ben Taylor, MD   Ken Cayce, MD

PFSH & ROS

Name_______________________________________ **DOB** ____________ **Age** ________________ **Sex** _____________
Height______________ **Weight**____________ **Family Physician:** ____
Occupation: ____
Who sent you to our office? ____
Reason for appointment: ____

____

Previous Operations: (Type and Date) ____

____

Medication Allergies: (Please List) ____

Do you have, or have you had any of the following conditions? (Please Circle)

Chest Pain	Yes	No		Stroke	Yes	No		Arthritis	Yes	No
Heart Attack	Yes	No		High Blood Pressure	Yes	No		Kidney Problems	Yes	No
Irregular Heart Beat	Yes	No		Diabetes	Yes	No		Respiratory Problems	Yes	No
Congestive Heart Failure	Yes	No		Cancer	Yes	No		Phlebitis/Blood Clot	Yes	No
Adverse reaction to anesthesia	Yes	No		Pulmonary Embolism	Yes	No		Hepatitis	Yes	No

Please List any other serious illness or injury: ____

____

Do You Smoke Cigarettes/Cigars   Yes   No   Amount______________________________
Do You Drink Alcohol   Yes   No   Amount______________________________
Do You Use Street Drugs   Yes   No   Amount______________________________

Please List Current Medication and Dosages:

______________________________   ________________________________   ______________________________

______________________________   ________________________________   ______________________________

Do you have a family history of any of the following conditions? If Yes, please list family member relationship:
Cancer and Type ______________________ **Stroke** ______________________ **Diabetes** _________________________

Hypertension _________________________ **Heart Disease** ________________ **Bleeding Problem** __________________

ROS: Do you have any of the following symptoms?

	Yes	No			Yes	No
Constitution Fever				**GI** Nausea/Vomiting		
Wt. Change Loss_____lbs Gain_____lbs				**GU** Painful Urination		
Eyes Blurred or Double Vision				Blood in Urine		
Loss of Vision				**Neuro** Convulsion/Seizures		
ENT Problems Swallowing/Food Stuck in Throat				Headaches		
Sore Throat				**MS** Joint Replacement		
CV Chest Pain				Muscle Weakness		
Palpitations				Deformity of Legs,Feet,Arms,Back		
Resp Shortness of Breath				Joint Swelling		
Persistent Cough				Persisent Muscle Pain		
GI Diarrhea				**Skin** Hives		
Constipation				Skin Rash		

Patient Signature_____________________ **Date**______ **Physician Signature**__________________ **Date**______