Bend Surgical Associates

Michael J. Mastrangelo, MD, FACS

PATIENT NAME: ____________________________ DATE OF BIRTH: _________

MEDICATIONS – Please list all of your current prescription, non-prescription medications, vitamins, minerals, and supplements.

O No medications

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

*** If more room is needed please use back of form or attach a list of all current medications**

Medication Allergies: (please list reaction next to allergy)

____

____

____

Bend Surgical Associates

Michael J. Mastrangelo, MD, FACS

PATIENT NAME: ______________________________ DATE OF BIRTH: _________

Please list all past Surgeries

O No previous surgeries

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

_________________________________ **Year:** _________ **Surgeon:** ____________

Patient Name: ______________________________DOB:_____________________

Family History

Does anyone in your family have a history of cancer? _________________________________

If yes what type of cancer and in which family member? ________________________________

	Age/Age at Death	Living	Disease History/Cause of Death
Father	____	Yes / No	___________________________________
			___________________________________
Mother	____	Yes / No	___________________________________
			___________________________________
Sibling (s)____		Yes/ No	___________________________________
	____		___________________________________
Children ____		Yes/ No	___________________________________
	____		___________________________________

Patient Name: ______________________________ DOB: ____________________

Social History

Fill in the bubbles completely (no check marks)

- O Single O Married O Widowed O Separated O Divorced
- O Retired O Unemployed O Employed O Self-employed O Student

Occupation: __________________________ If Retired, from what occupation: ____________________

- Smoking /Chewing Tobacco O Currently O Quit Year quit: _______ O Never

How long have you (or did you) smoke(d)? _______ How many cigarettes do you (or did you) smoke per day? ______

How often do you smoke? (Circle one) Everyday Some days

How soon after you wake up do you smoke your first cigarette? (Circle One)

5 minutes 6-30 minutes 31-60 minutes after 60 minutes

- Alcohol O Rarely O Socially O Daily O Quit O Never

How much alcohol do you drink____

- Recreational drugs O No O Yes O Quit If yes/Quit, what type? _________________________

Current IV Drug use O No O Yes History of IV Drug use O No O Yes

Patient Name: ______________________________DOB:_____________________

Past Medical History:

Check all of the following that you have experienced or have ever been diagnosed with in the past:

Please fill in Circle completely (no check marks)

Heart:	**YES:**	**NO:**
Chest pain/chest tightness	O	O
Heart disease	O	O
Heart attack	O	O
Heart murmur	O	O
High Cholesterol	O	O
High blood pressure	O	O
Ear-Nose-Throat-Lungs:		
Asthma	O	O
COPD	O	O
Emphysema	O	O
Tuberculosis	O	O
General:		
Anemia	O	O
Anxiety disorder	O	O
Cancer Type: _________	O	O
Depression	O	O
Hypothyroidism	O	O

	YES:	**NO:**
Type I diabetes - Ins. dependent	O	O
Type 2 diabetes	O	O
Lupus	O	O
Kidney/Bladder:		
Kidney stones	O	O
Kidney disease	O	O
Renal failure, acute	O	O
Renal failure, chronic	O	O
HIV	O	O

Other Medical History not listed:

____

____

____

Musculoskeletal:	**YES:**	**NO:**
Arthritis	O	O
Gout	O	O
Osteoporosis	O	O

Patient Name: ______________________________DOB:_____________________

Abdomen:	**YES**	**NO**
Barrett's esophagitis	O	O
Blood in stool	O	O
Cirrhosis	O	O
Colon polyps	O	O
Constipation	O	O
Diarrhea	O	O
Diverticulosis	O	O
Stomach ulcer	O	O
Fatty liver	O	O
Gall bladder disease	O	O
GI bleed, lower	O	O
GI bleed, upper	O	O
Hepatitis B	O	O
Hepatitis C	O	O
Hemorrhoids	O	O
Hernia type____________	O	O
Irritable bowel syndrome (IBS)	O	O
Ulcerative colitis	O	O
Reflux	O	O

Neurological	**YES**	**NO**
Migraines	O	O
Parkinson's disease	O	O
MS	O	O
Alzheimer's	O	O
Stroke	O	O
Seizures	O	O

Patient Name: ______________________________DOB:_____________________

Review of systems – Fill in all of the following that apply to <u>this visit today only</u>

Please fill in the bubbles completely (no check marks)

Constitutional		**YES:**
Fatigue		O
Fever		O
Loss of appetite		O
Unexplained weight change	O Gain	O Loss
Gastroenterology		
Abdominal pain		O
Blood in stool		O
Change in bowel habits		O
Constipation		O
Diarrhea		O
Heartburn		O
Nausea		O
Vomiting		O
Cardiology		
Chest pain		O
Dizziness		O
Palpitations		O

	YES:
Shortness of breath	O
ENT/Respiratory	
Change in voice	O
Cough	O
Musculoskeletal	
Joint pain	O
Joint swelling	O
Hematology	
Unexplained Bruising	O
Easy bleeding	O
Dermatology	
Hives	O
Skin cancer	O
Rash	O
Neurology	
Headache	O

Patient Name: ____________________________DOB:____________________

Memory loss O

YES

Sleep Apnea O

Psychology

Anxiety O

Depression O

Eating disorder O

Mental or physical abuse O

Sexual abuse O

Abnormal Tension/stress O

YES

Genitourinary female

Difficulty urinating O

Heavy periods O

Painful periods O

Number of Pregnancies: _____________

Number of deliveries: ______________

Genitourinary male

Difficulty urinating O

Hard testicle O

Incontinence or dribbling O

Increased urinary frequency O