Advanced Surgical of North Texas

Patient Name:	**DOB:**	**Date:**
Referring Provider or PCP:		

Medical History: *(Circle all that apply)*					
	High blood pressure	Diabetes	Arthritis	Heartburn	Seizures
	Bleeding/bruising	Chronic pain	Heart problems	Asthma	Stroke
	Urinary problems	Kidney disease	Cancer	Skin lesions	Thyroid
	Other:				

Past Surgeries: *(Please list)*	

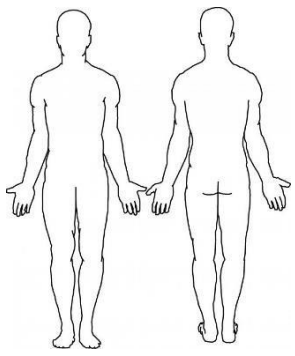
Medications: *(Please use back of form if additional space is needed)*
1.
2.
3.
4.
5.

Allergies: *(Circle all that apply and list the reaction, if applicable)*			
NONE	Penicillin Reaction:	Sulfa Reaction:	Codeine Reaction:
Other: *(Please list)*			

Social History	**Y/N**	**How much?**	**Family History**	**Y/N**	**If yes, list type and family member**
Tobacco			Cancer		
Alcohol			Bleeding disorder/Stroke		
Drugs			Other		

FOR OFFICE USE ONLY

Reason for appointment:



Assessment:

Height:
Weight:
BP:
Temp:
Pulse:

Labs/Imaging:	**Plan:**
CBC BMP EKG CXR PCP for clearance	MMH/CR THR MCF MCM
Follow up: _____PRN	Pharmacy: