Collin County Surgeons
4510 Medical Center Drive, Suite 214
McKinney, Texas 75069
(214)592-9200 Office

Patient Name _____

Today's Date _____

Birthdate _____

Medical History

Please take a few minutes to answer questions about your medical history below:

Past Medical History (Circle all that apply)

Diabetes	Heart problems	Stroke	Bowel disorders
High blood pressure	Kidney disease	Thyroid disease	Lung disease
			Other:_____

Past Surgical History(Circle all that apply)

Hernia	Appendix	Ovaries	Heart surgery/stents
Gallbladder	Hysterectomy	Breast Surgery	Other:_____

Medications (including any over the counter medications)

Drug	Dose and Frequency		Drug	Dose and Frequency

Drug allergies **None**

Drug	Reaction

Social History

Do you work? Y N Full-time Part-time Where? _____

Do you use tobacco? Y N Packs/day or smokeless? _____ How long? _____

Do you drink alcohol? Y N How much and how often? _____

Do you use street drugs or misuse prescription drugs? Y N

Family History

Is there any history of the following medical conditions in your family? Please circle.

Heart disease	Lung disease	Bowel disease
Kidney disease	Diabetes	Cancer (Type?)

Other _____

Review of Systems. Please circle "Y" or "N".

General

Fevers/chills Y/N Weight loss Y/N Weight gain Y/N

Eyes

Vision problems Y/N Double vision Y/N

Ears/Nose/Mouth/Throat

Difficulty hearing Y/N Dental problems Y/N Mouth sores Y/N
Sinus problems Y/N

Cardiovascular

Chest pain Y/N Irregular heartbeat Y/N Heart failure Y/N
Difficulty exercising Y/N

Respiratory

Shortness of breath Y/N Chronic cough Y/N Pneumonia Y/N
Have you ever been diagnosed with TB? _____ If "yes," when? _____
Have you ever been exposed to TB? _____ If "yes," when? _____
When was your last TB skin test? _____

Gastrointestinal

Difficulty swallowing Y/N Diarrhea Y/N Rectal bleeding Y/N
Pain with swallowing Y/N Constipation Y/N Hepatitis Y/N
Heartburn (GERD) Y/N Hemorrhoids Y/N Gallstones Y/N
Irritable Bowel Y/N Incontinent of stool Y/N

Genitourinary

Burning with urination Y/N Blood in urine Y/N Kidney stones Y/N
Incontinence of urine Y/N

Musculoskeletal

Joint pains Y/N Back pain Y/N Weakness Y/N

Skin and Breast

History of skin cancer Y/N Breast biopsies in the past Y/N History of breast cancer Y/N
Skin lesions Y/N

Neurological

Headaches Y/N History of stroke/TIA Y/N

Psychiatric

Anxiety Y/N Depression Y/N Other_____

Endocrine

Diabetes Y/N
Pancreatitis Y/N
Thyroid problems Y/N
Parathyroid disease Y/N
Adrenal disease Y/N

Hematologic/Lymphatic

Leukemia/Lymphoma Y/N Anemia Y/N Transfusions Y/N

Allergic/Immunologic

Immune disease or HIV Y/N Latex allergy Y/N

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