THREE RIVERS SURGICAL CARE

an affiliate of SCA

3800 West Okmulgee
Muskogee, OK 74401

Name: ______________________ Age: __________ Date: ______________

SYMPTOMS Check ( ) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulder

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful Urination

RESPIRATORY

- ☐ Smoke
- ☐ Asthma
- ☐ Cough
- ☐ Cold
- ☐ Exposed to Tuberculosis

Do you have these TB symptoms:
Please Circle:

Cough, bloody sputum, fever
Night sweats, weight loss, or
HIV/AIDS

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Abnormal EKG
- ☐ Abnormal Chest X-ray

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Changes in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstral period

____

Date of last Pap Smear

____

Are you pregnant? __________

Number of children __________

MEDICAL HISTORY Check ( ) the medical conditions you have or have had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall Bladder Disease
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease/Heart Attack
- ☐ Hepatitis
- ☐ Nosebleeds
- ☐ Hernia/Hiatal Hernia
- ☐ Heart Murmur
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Veneral Disease

Current Weight ____________

CONFIDENTIAL HEALTH HISTORY

ANESTHESIA HISTORY			
	YES	NO	IF YES, PLEASE EXPLAIN
1. Have you ever had an anesthetic?			
2. Have you ever had a problem with Anesthesia?			
3. Has any one related to you ever had a problem with Anesthesia?			

HOSPITALIZATIONS\SURGERIES\SERIOUS ILLNESS\INJURIES		
Year	Hospital	Reason for Hospitalizations and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates:____

HEALTH HABITS Check ( ) which substances you use and indicate how much you use per day/week
☐ Caffeine
☐ Tobacco
☐ Drugs
☐ Alcohol
☐ Street Drugs

PREGNANCY HISTORY		
Year of Birth	Sex of Birth	Complications if any

FAMILY HISTORY Fill in health information about your family						
		State of	Age at		Check ( ) if your blood relatives had any of the following	
Relation	Age	Health	Death	Cause of Death	Disease	Relationship to you
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

I certify that the above information is correct to the best of my knowledge. I will not hold Three Rivers Surgical Care or its Staff/Physicians responsible for any errors or omissions that I may have made in the completion of this form.

________________________________ ____________________
Signature Date