DSS
Desert Surgical Specialists

Rick A. Low, M.D.
Sam Durrani, M.D.
Kaavya Matatova M.D.
Ben Hanshaw, D.O.
19646 North 27th Avenue, Suite 201
Phoenix, AZ 85027
(602) 663-9371 Main
(602) 456-6887 Fax

PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M PCP: _____

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

ALLERGIES

Drug allergies: ❑ No ❑ Yes To what?

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer Type:_____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
  - ❑ Atrial fibrillation/irregular heartbeat
  - ❑ CHF: congestive heart failure
  - ❑ MI: heart attack
  - ❑ Other: _____
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

_____

_____

SOCIAL HISTORY

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Tobacco use: ❑ Never smoker ❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker

Alcohol use: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Illicit drug use: ❑ None ❑ Socially ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly Type:_____

Religious beliefs that may affect medical care: _____

FAMILY HISTORY

	Family Member (please list)
❑ Cancer Type: _____	_____
❑ Coronary Artery Disease	_____
❑ Dementia	_____
❑ Diabetes	_____
❑ Kidney Disease	_____
❑ Malignant Hyperthermia	_____
❑ Multiple Endocrine Neoplasia	_____
❑ Myasthenia Gravis	_____

Other family history (please list):

_____

PAST SURGICAL HISTORY

Please list any surgeries you have had: _____

_____

_____

HEALTH MAINTENANCE HISTORY

Colonoscopy: Date:_____
Mammogram: Date:_____
Pap Smear: Date:_____

WOMENS REPRODUCTIVE HISTORY

Age of first period: _____
Pregnancies:_____
Miscarriages:_____
Abortions:_____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCULOSKELETAL
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

RESPIRATORY
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NEUROLOGICAL
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

GASTROINTESTINAL
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

HEMATOLOGY
- ❑ Anemia
- ❑ Clots

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS: