SWAN SURGICAL
CARDIAC THORACIC VASCULAR

New Patient History

Name: ________________________ Date of Birth: ________________

Patient Referred by: ________________ Patient's Primary Care Physician: ________________

Reason for Referral: ____

Past Medical History (List any medical problems you have):

1. ____________ 4. ____________ 7. ____________
2. ____________ 5. ____________ 8. ____________
3. ____________ 6. ____________ 9. ____________

Surgery/Trauma History (List the operations or injuries you have had, along with the month, year, and hospital):

1. ____________ 3. ____________ 5. ____________
2. ____________ 4. ____________ 6. ____________

Have you or any family members ever had a reaction to anesthesia? (Circle) YES NO

Bleeding Problems? (Circle) YES NO

Review of Systems (Check the appropriate box if you have had these symptoms recently):

YES	NO		YES	NO		YES	NO		YES	NO	
___	___	Fevers	___	___	Chest pain	___	___	Vomiting	___	___	Mole changes
___	___	Night sweats	___	___	Ankle swelling	___	___	Vomiting blood	___	___	Breat lumps, pain
___	___	Fatigue	___	___	Calf pain	___	___	Upper abdominal pain	___	___	Nipple discharge
___	___	Weight changes	___	___	Short of breath	___	___	Lower abdominal pain	___	___	Dizziness
___	___	Double vision	___	___	Irregular pulse	___	___	Yellow Jaundice	___	___	Seizures
___	___	Wear glasses/contacts	___	___	Cough	___	___	Painful urination	___	___	Numbness or tingling
___	___	Hearing Loss	___	___	Diarrhea	___	___	Blood in urine	___	___	Anxiety
___	___	Ear pain or discharge	___	___	Constipation	___	___	Kidney stones	___	___	Depression
___	___	Bloody nose	___	___	Bloody stools	___	___	Joint or muscle pain	___	___	Excessive hair growth
___	___	Nasal discharge	___	___	Difficulty swallowing	___	___	Decreased mobility, weakness	___	___	Easy bruising
___	___	Hoarseness	___	___	Heartburn	___	___	Joint swelling	___	___	Bleeding tendency
___	___	Oral ulcers	___	___	Nausea	___	___	Skin rash	___	___	Swollen nodes

Menstrual History Age of onset: _____ Age of Menopause: ______ Number of Pregnancies: ______ Live Births: ______

Miscarriages: ____ Last Menstrual Period: _____ Age of first pregnancy: _____Do you take birth control pills? YES NO

Social History Marital Status: _______ Number of Children: ___________ International Travel?: ______________

Occupation: ______________________________ Do you do heavy lifting on a dialy basis?(Circle) YES NO

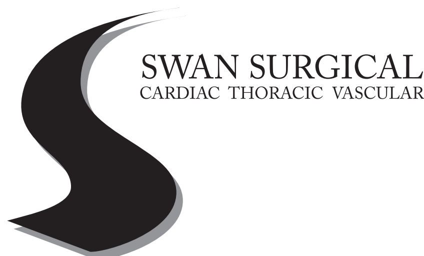
Cigarette Smoking I have smoked ___ packs per day for ___ years. I quit smoking in ______ Drug use? ______________

Please describe your alcohol intake (Check one): ___ None ___ Occasional ___ 1-2 Drinks per day ___ >2 Drinks per day

Family History (Check the box if you have first degree relatives (Mother, Father) with the following cancers or diseases):

__ Breast Cancer	__ Skin Cancer	__ Inflammatory bowel disease	__ Thyroid disease
__ Ovarian Cancer	__ Lymphoma	__ Brain tumors	__ Prathyroid disease
__Colon Cancer	__ Leukemia	__ Heart disease	__ Other: ________________

Reviewed by: ______________________________ **Date:** ________________



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