MERIDIAN MEDICAL GROUP

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DEPARTMENT OF SURGERY
JERSEY SHORE UNIVERSITY MEDICAL CENTER

Name: _____

Date of Birth: _____ **Age:** _____

Advance Medical Directive: Do you have an Advanced Directive (Medical Power of Attorney, Living Will, Proxy Directive, Instruction Directive, etc.)? ☐ **YES** ☐ **NO**
If so: Your Health Care Representative is _____

Primary Care Physician: _____
Address: _____
_____
Phone: _____

Referred By: _____
Address: _____
_____
Phone: _____

Major Complain/Problem: _____
_____
_____
_____

Date/Onset of Symptoms: _____
Symptoms include: _____
_____
_____
_____

Other Conditions/Problems: _____
_____
_____

All Previous Operations: _____
(include Date/Year) _____
_____
_____

List All Medication and Dose: _____
_____
_____
_____

List All Known Allergies: _____

_____

_____

_____

Do You Smoke Cigarettes? ☐ **YES** ☐ **NO** **How Many Per Day:** _____

Alcohol Consumption: ☐ **YES** ☐ **NO**

How Often: _____

List Immediate (<u>Blood</u> Relatives) Family Member's Age and Health Status: _____

_____

_____

_____

_____

(If not living age and cause of death): _____

_____

_____

_____

_____

Did any Family Members have similar Problems: _____

_____

_____

Any Thyroid and/or Parathyroid Problems: _____

_____

_____

History of Cancer in the Family: _____

_____

_____

Review of systems:

1. **Have you been experiencing fever or night sweats, or are you tired all the time?** ☐ **YES** ☐ **NO**

Describe: _____

_____

2. **Have you had weight loss over 5 pounds, fatigue, malaise?** ☐ **YES** ☐ **NO**

Describe: _____

_____

3. **Do you have eye or vision problems?** ☐ **YES** ☐ **NO**

Describe: _____

_____

4. **Do you have any problems with your hearing, ears, nose, mouth, throat, or sores in your mouth?** ☐ **YES** ☐ **NO**

Describe: _____

_____

5. Do you have difficulties swallowing? ☐ YES ☐ NO

Describe:_____

_____

6. Do you have any hoarseness or voice changes? ☐ YES ☐ NO

Describe:_____

_____

7. Do you experience chest pains, difficulty breathing while lying down, rapid heart beat, swelling in your ankles? ☐ YES ☐ NO

Describe:_____

_____

8. Do you have chronic cough, or cough up blood, or wheeze, or have any lung problems? ☐ YES ☐ NO

Describe:_____

_____

9. Do you have a history of radiation? ☐ YES ☐ NO

Describe:_____

_____

10. Do you have wheezing, or experience shortness of breath? ☐ YES ☐ NO

Describe:_____

_____

11. Do you have any problems with indigestion, heartburn, abdominal pains or cramps, difficulty with or change in bowel habits or have you seen blood in the toilet with a bowel movement? ☐ YES ☐ NO

Describe:_____

_____

12. Do you have any known diseases or problems with your stomach, gallbladder, intestines, colon or rectum? ☐ YES ☐ NO

Describe:_____

_____

13. Do you have irregular menstrual periods or vaginal bleeding? ☐ YES ☐ NO

Describe:_____

_____

14. Do you have any known problems or diseases of the kidneys, bladder, prostate, or female organs? ☐ YES ☐ NO

Describe:_____

_____

15. Do you have any problems with your bones, joints, and muscles such as arthritis or rheumatism? ☐ YES ☐ NO

Describe:_____

_____

16. Do you have any skin disorders or breast problems such as a lump or nipple discharge? ☐ YES ☐ NO

Describe:_____

_____

17. Do you have any nervous disorder, or problems such as numbness, tingling, muscle weakness? ☐ YES ☐ NO

Describe:_____

_____

18. Have you had problems with depression, phobias, suicidal thoughts, hallucinations, or other psychiatric problems? ☐ YES ☐ NO

Describe:_____

_____

19. Do you have diabetes, or known disorders of the adrenal? ☐ YES ☐ NO

Describe:_____

_____

20. Do you have anemia, bleed easily, bruise easily, or have any known blood disorders? ☐ YES ☐ NO

Describe:_____

_____

21. Do you suffer from hay fever, asthma or have any other allergies? ☐ YES ☐ NO

Describe:_____

_____

22. Do you have problems with infections or healing wounds? ☐ YES ☐ NO

Describe:_____

_____

23. Do you have a history of hepatitis? ☐ YES ☐ NO

Describe:_____

_____

24. Have you ever received a blood or plasma transfusion? ☐ YES ☐ NO

Describe:_____

_____