

Asante Surgical Associates—Medical Questionnaire

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Nabiel Azar, DO

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Name: _____

Date: _____

Please list all operations that you have had including angioplasty, endoscopy, or cosmetic surgery:

<u>Surgery</u>	<u>Year Performed</u>
1.	
2.	
3.	
4.	
5.	

Have you had a colonoscopy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What year was the last one? _____
Have you been hospitalized in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
For what problem?			

If female, is there a chance you could be, or are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How many deliveries have you had? Vaginal: ____ C-section: ____ Reason for C-section:			
Age of first menstrual period: _____ Age of last menstrual period if postmenopausal: _____			

Please indicate if you use any of the following substances:

Problem	No	Yes	How much:	How long:
Do you currently smoke	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	Years: _____ Quit <input type="checkbox"/>
Do you drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>		
Do you use illicit drugs	<input type="checkbox"/>	<input type="checkbox"/>	What:	

Please list any family members that have been diagnosed with any of the following problems:

Problem	Family Member—Please list all that apply
Blood clotting problems	
Breast cancer	
Diabetes	
Heart attack	
Heart disease	
Heart surgery	
High blood pressure	
Stroke	
Thyroid cancer	

Has any family member been diagnosed with Colon Cancer or Polyps? Please check here if **NO**

Family Member	Colon/Rectal Polyp	Colon/Rectal Cancer	Age at Diagnosis
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

Has any family member been diagnosed with any other cancer? If not please check: NONE

Family Member	Type of Cancer	Age at Diagnosis

Has any family member been diagnosed with any of these problems? If not please check: NONE

Disease	YES	Which Relative (s)?
Brain cancer	<input type="checkbox"/>	
Crohn's disease	<input type="checkbox"/>	
Endometrial cancer	<input type="checkbox"/>	
Esophageal	<input type="checkbox"/>	
Liver cancer	<input type="checkbox"/>	
Multiple colon polyps or polyp syndromes (FAP, HNPCC).	<input type="checkbox"/>	
Ovarian cancer	<input type="checkbox"/>	
Skin cancer	<input type="checkbox"/>	
Small intestinal cancer	<input type="checkbox"/>	
Stomach cancer	<input type="checkbox"/>	
Ulcerative colitis	<input type="checkbox"/>	
Urinary cancer	<input type="checkbox"/>	

Please check any of the following YOU have experienced within the last year?

Problems	Yes	Problems	Yes
General, constitutional		Painful bowel movements or constipation	<input type="checkbox"/>
Fever, chills or night sweats	<input type="checkbox"/>	Weight changes	<input type="checkbox"/>
Wt. loss of > 15 lbs in the last 6 months	<input type="checkbox"/>	Genitourinary	
Eyes		Blood or air bubbles in urine	<input type="checkbox"/>
Blurred or double vision	<input type="checkbox"/>	Burning or painful urination	<input type="checkbox"/>
Eye disease or injury	<input type="checkbox"/>	Sexual difficulty	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Neurologic	
Ears, nose, throat		Convulsions	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	Frequent or recurrent headaches	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	Numbness in hands or feet	<input type="checkbox"/>
Breast		Paralysis	<input type="checkbox"/>
Breast feeding: How long?	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Drainage: Color?	<input type="checkbox"/>	Tingling sensation	<input type="checkbox"/>
History breast biopsies	<input type="checkbox"/>	Tremors	<input type="checkbox"/>
History breast cancer	<input type="checkbox"/>	Musculoskeletal	
History breast masses	<input type="checkbox"/>	Back pain	<input type="checkbox"/>
Hormone replacement therapy	<input type="checkbox"/>	Joint pain—difficulty in walking	<input type="checkbox"/>
Cardiovascular		Weakness of muscles/joints	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	Endocrine	
Heart flutters	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Respiratory		Excessive fatigue	<input type="checkbox"/>
Asthma or wheezing	<input type="checkbox"/>	Excessive thirst or urination	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>
Use of CPAP machine	<input type="checkbox"/>	Psychiatric	
Gastrointestinal		Depression or anxiety	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	Memory loss or confusion	<input type="checkbox"/>
Bloating or cramping	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>
Difficulty with swallowing	<input type="checkbox"/>	Hematologic/Lymphatic	
Frequent diarrhea	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Heart burn	<input type="checkbox"/>	Easy bruise or bleed	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	Heavy menstrual bleeding	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	History of blood transfusions	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>		

Please check all of that YOU have been diagnosed with:

Problem	Yes	Problem	Yes	
General		Other		
Anxiety	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	Bleeding problems; hemophilia, ITP	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	Blood clot in legs	<input type="checkbox"/>	
High cholesterol	<input type="checkbox"/>	Blood clot in lungs	<input type="checkbox"/>	
Heart		Diabetes	<input type="checkbox"/>	
Ankle/Leg swelling	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	
Aortic or mitral valve disease (heart murmur)	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	
Artificial heart valve:	<input type="checkbox"/>	Gout	<input type="checkbox"/>	
Mitral valve	<input type="checkbox"/>	Heart burn/reflux	<input type="checkbox"/>	
Aortic valve	<input type="checkbox"/>	Hip replacement	<input type="checkbox"/>	
Chest pain with exertion (angina)	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	
Claudication (pain in legs with exercise)	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	
Congestive heart failure	<input type="checkbox"/>	Knee replacement	<input type="checkbox"/>	
Fainting/lightheadedness	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	
Implanted defibrillator/pacemaker	<input type="checkbox"/>	Pulmonary embolism	<input type="checkbox"/>	
Irregular heart beat (arrhythmia)	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	
Previous heart attack – Year:	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	
Lungs		Cancer		Age
Abnormal chest x-ray	<input type="checkbox"/>	Brain tumor	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	Breast	<input type="checkbox"/>	
Chronic cough	<input type="checkbox"/>	Cervical	<input type="checkbox"/>	
Emphysema/COPD	<input type="checkbox"/>	Colon	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	Head/Neck	<input type="checkbox"/>	
Shortness of breath with exertion	<input type="checkbox"/>	Liver	<input type="checkbox"/>	
Shortness of breath with lying flat	<input type="checkbox"/>	Lung	<input type="checkbox"/>	
Kidneys/Bladder		Prostate	<input type="checkbox"/>	
Blood in urine	<input type="checkbox"/>	Ovarian	<input type="checkbox"/>	
Frequent bladder infections (UTI)	<input type="checkbox"/>	Rectal	<input type="checkbox"/>	
Frequent urination at night	<input type="checkbox"/>	Skin	<input type="checkbox"/>	
Kidney stones	<input type="checkbox"/>	Small intestine	<input type="checkbox"/>	
Leakage of urine - incontinence	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	
Prostate enlargement (BPH)	<input type="checkbox"/>	Uterine	<input type="checkbox"/>	
		Other Cancers:	<input type="checkbox"/>	

Please list any allergies you may have to medicine, food, or other items:

Allergy	What symptoms do you experience?