Advanced Surgical of North Texas

Patient Name:	DOB:	Date:
Referring Provider or PCP:		

Medical History: *(Circle all that apply)*	High blood pressure	Diabetes	Arthritis	Heartburn	Seizures
	Bleeding/bruising	Chronic pain	Heart problems	Asthma	Stroke
	Urinary problems	Kidney disease	Cancer	Skin lesions	Thyroid
	Other:				

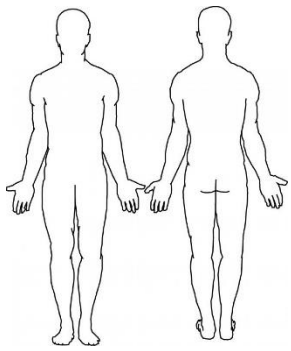
Past Surgeries: *(Please list)*	

Medications: *(Please use back of form if additional space is needed)*			
1.			
2.			
3.			
4.			
5.			
Allergies: *(Circle all that apply and list the reaction, if applicable)*			
NONE	Penicillin Reaction:	Sulfa Reaction:	Codeine Reaction:
Other: *(Please list)*			

Social History	Y/N	How much?	Family History	Y/N	If yes, list family member(s)
Tobacco			Cancer		
Alcohol			Bleeding disorder/Stroke		
Drugs			Other		

FOR OFFICE USE ONLY

Reason for appointment:



Assessment:

Height:
Weight:
BP:
Temp:
Pulse:

Labs/Imaging:	**Plan:**
Follow up: _____ PRN	___ EMR ___ Scanned ___ Dictated ___ Complete