RODNEY C. BIGGS, MD, PC
GENERAL SURGERY

Please indicate your past medical history and family medical history by checking the appropriate boxes. Please include family member's relationship to you, i.e. mother, daughter, grandfather, etc. For other medical diseases not listed, please use the lines below the table.

Problem:	Self: ☑	Family Member: ☑	Relationship	Problem:	Self: ☑	Family Member: ☑	Relationship
Alcohol Abuse	☐	☐		Diverticulosis/diverticulitis	☐	☐	
Anemia, low blood count	☐	☐		Epilepsy/ seizures	☐	☐	
Anesthesia problems	☐	☐		Gallbladder disease	☐	☐	
Anxiety	☐	☐		Glaucoma	☐	☐	
Arthritis/ Gout	☐	☐		Heart attack	☐	☐	
Asthma	☐	☐		Heart failure	☐	☐	
Bleeding tendency	☐	☐		Hepatitis/ liver disease	☐	☐	
Cancer, Breast	☐	☐		High blood pressure	☐	☐	
Cancer, Cervix/Ovary/Uterus	☐	☐		High cholesterol	☐	☐	
Cancer, Colon	☐	☐		Inflammatory bowel disease	☐	☐	
Cancer, Lung	☐	☐		Irritable bowel syndrome	☐	☐	
Cancer, Prostate	☐	☐		Kidney disease	☐	☐	
Cancer, Skin	☐	☐		Obesity	☐	☐	
Cancer, Other _____	☐	☐		Stroke	☐	☐	
COPD/ Emphysema	☐	☐		Thyroid disease	☐	☐	
Depression	☐	☐		Ulcers	☐	☐	
Diabetes	☐	☐		Vascular disease	☐	☐	

Other medical illnesses, not listed above: _____

_____

Medications and Dosage: Please include vitamins and over-the-counter medications. **NONE:** ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies and Adverse Reactions: Please describe. **(antibiotics, anesthetics, narcotics, latex, tape, etc.)** **NONE:** ☐

_____

_____

Please make sure both sides of form are completed.

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Previous Surgeries and Date Performed: **NONE:** ☐

(Appendectomy, Gallbladder, Laparoscopy, C-section, Tubal ligation, Tonsils, Breast biopsies, Colonoscopy/endoscopy, Joint or Bone surgeries, Heart angioplasty or stents, etc.)

_____

_____

_____

_____

_____

Social History:

☐Married ☐Single ☐Divorced ☐Widowed Occupation: _____

Do you drink alcohol? _____ How Much? _____ How Often? _____

Have you ever smoked? _____ How many years did you smoke? _____ When did you quit? _____

Do you use chewing tobacco? _____ How many packs/cans per day do you smoke/chew now? _____

Do you use illicit/illegal drugs? _____ What kind and how often? _____

Review of Systems: Check all that apply.

Constitutional: ☐Fatigue ☐Fever ☐Chills ☐Fainting ☐Weight loss ☐Weight gain

Eyes: ☐Double vision ☐Change in vision ☐Blindness

Ear, Nose, Throat: ☐Difficulty hearing ☐Congestion ☐Runny nose ☐Nose bleeds ☐Sore throat

Cardiovascular: ☐Chest pain ☐Skipped/extra heart beats ☐Leg pain when walking ☐Leg/ankle swelling

Respiratory: ☐Shortness of breath ☐Cough ☐Wheezing ☐Sputum

Gastrointestinal: ☐Abdominal pain ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Blood in bowel movements ☐Difficulty swallowing/chewing ☐Hemorrhoids

Genitourinary: ☐Painful urination ☐Bloody urine ☐Kidney stones ☐Groin hernia

Musculoskeletal: ☐Difficulty walking ☐Arthritis ☐Back pain

Skin: ☐Yellow skin (jaundice) ☐Skin rash ☐Skin problems _____

Neurologic: ☐Headache ☐Dizziness ☐Seizures ☐Confusion

Psychologic: ☐Stress ☐Depression ☐Anxiety ☐Poor sleeping

Endocrine: ☐Thirsty ☐Cold intolerance ☐Heat intolerance

Hematologic: ☐Easy bruising or bleeding ☐Low blood count/ anemia

Immunologic: ☐Splenectomy ☐HIV/AIDS ☐Seasonal allergies

Lymphatics: ☐Swollen lymph glands

Any other symptom(s) that your surgeon should know about: _____

_____

Printed Name: _____ Signature: _____ Date: _____

Please make sure both sides of form are completed.