□ Paul Brock, MD □ Clarence Mckemie, MD
□ James Riley, MD □ Ryland Scott, MD
□ Kelly Mayfield, MD

HARBIN CLINIC
GENERAL SURGERY

Patient Information Form

Name _____ Age _____ Date of Birth _____ Date _____
Family Physician _____ Referring Physician _____

Present Illness
What is the reason for your visit today? _____ When did this begin? _____
What symptoms are you having? _____
What tests have you had? _____
What treatments have you tried? _____

Past Medical History (Self) Please check any that apply and explain

□ Bleeding Disorder _____
□ Cancer _____
□ Diabetes _____
□ Heart Disease _____
□ High Blood Pressure _____
□ Lung Disease _____
□ Abnormal Heart Rhythm _____
□ Anemia _____
□ Congestive Heart Failure _____
□ Deep Vein Thrombosis _____
□ GERD/Reflux _____
□ Gastrointestinal Disease _____
□ Heart Attack (MI) _____
□ Hepatitis _____
□ High Cholesterol _____
□ Kidney Disease _____
□ Latex Allergy _____
□ Leg Swelling _____
□ Liver Disease _____
□ Other _____
□ Psychiatric Illness _____
□ Seizures/Epilepsy _____
□ Sleep Apnea _____
□ Stomach Ulcer _____
□ Stroke _____
□ Thyroid Problems _____

Last Mammogram Date: _____ □ Normal □Abnormal (why?) _____
Last Colonoscopy Date: _____ □ Normal □Abnormal (why?) _____

Past Surgical History

Procedure	Date	Notes

Current Medications

Medication	Dosage and How Often	Reason

□ Paul Brock, MD □ Clarence Mckemie, MD
□ James Riley, MD □ Ryland Scott, MD
□ Kelly Mayfield, MD

HARBIN CLINIC

GENERAL SURGERY

Pharmacy_____ **Allergies**_____
Location _____ _____

Family History (Immediate Family)

	Mother	Father	Brother	Sister	Other
High Blood Pressure	□	□	□	□	□ _____
Diabetes	□	□	□	□	□ _____
Heart Disease	□	□	□	□	□ _____
Lung Disease	□	□	□	□	□ _____
Bleeding Disorder	□	□	□	□	□ _____
Cancer	□	□	□	□	□ _____

Social History

Marital Status □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner
Tobacco Use □ Never □ Former □ Current ___ Pack(s) a Day for ___ Years From Age ___ to ___
Alcohol Use □ No □ Yes
If Yes: Male- Do you consume more than 4 drinks/day & more than 14 drinks/week □ No □ Yes
Female- Do you consume more than 3 drinks/day & more than 7 drinks/week □ No □ Yes
Illegal Drug Use □ Never □ Yes Type _____
Occupation _____ Highest education level obtained _____
Is a Blood Transfusion Acceptable in an Emergency? □ No □ Yes

Review of Systems (Do You CURRENTLY have a problem with any of the following?)

□ Weight gain/loss ___#	□ Change in Stool	□ Weakness
□ Fever	□ Blood in Stool	□ Nosebleeds
□ Numbness/ Tingling	□ Indigestion/ Heartburn	□ Sinus Problems
□ Trouble Walking	□ Shortness of Breath	□ Urinary Problems
□ Lethargy	□ Chest Pain	□ Kidney Stones
□ Nausea	□ Palpitations	□ Wheezing
□ Vomiting	□ Swelling	□ Slow Healing
□ Difficulty Swallowing	□ Skin Changes	□ Bleeding Disorder
□ Constipation	□ Joint Pain	□ Immunodeficiency
□ Bloating	□ Muscle cramps/ pain	□ Breast Symptoms

Additional Information Is there anything else, not already addressed, that we should know about you in order to provide more complete medical care?

_____
_____
_____

_____
Patient Signature/ Date

_____
Physician Signature/ Date

Nurse Use Only
Ht: _____
Wt: _____
BP: ____/____
P: _____
R: _____
T: _____
Notes:
_____
_____
_____
_____
_____