REV. 11/30/2012

BENRUS SURGICAL at BARNES JEWISH ST. PETERS

Today's Date: ______________
Name: ______________________________________ Date of Birth: ______________

Do you have an Advance Care Plan/Living Will: Yes No

Why are you seeing the doctor today? ______________________________________
Referring Physician: ____
Primary Care Physician: ____

MEDICATIONS:

Medication	Dose	How Often?	Side Effects

DRUG ALLERGIES:

____
____

REVIEW OF SYSTEMS:

Are you currently or have you had problems with your :

Describe all YES responses

Eye	No	Yes ______________________________
Ears, Nose, Throat	No	Yes ______________________________
Lungs/Breathing (COPD)	No	Yes ______________________________
Stomach	No	Yes ______________________________
Colon	No	Yes ______________________________
Bladder (urination)	No	Yes ______________________________
Diabetes	No	Yes ______________________________
High Blood Pressure	No	Yes ______________________________
Bleeding Problems	No	Yes ______________________________
Heart	No	Yes ______________________________
Asthma	No	Yes ______________________________
Psychological Problems	No	Yes ______________________________
AIDS	No	Yes ______________________________
Cancer	No	Yes ______________________________
Arthritis	No	Yes ______________________________
Epilepsy	No	Yes ______________________________
Other	No	Yes ______________________________

____

Reviewed by: ____________________________________ Date: _______________
Physician's Signature

BENRUS SURGICAL at BARNES JEWISH ST. PETERS

NAME:____ **Today's Date**____________________
Date of Birth____________________

PAST MEDICAL HISTORY

Surgeries / Hospitalizations　　Year　　Complications

____
____
____
____
____
____
____

Have you had problems with general anesthesia?　NO______　YES_______
If yes Describe:____

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Mother				
Father				
Sister				
Brother				
Sister				
Brother				

SOCIAL HISTORY

☐ Work in the home　☐ Employed (occupation) ________________________________ ☐ Student

☐ Single　☐ Married　☐ Divorced　☐ Separated　☐ Widowed

☐ Children　☐ Yes　☐ No　Number of Children______

HISTORY OF SUBSTANCE ABUSE? ☐ Yes ☐ No　What? ____

☐ Smoke current?　Number of packs per day _______ for ______________years.

☐ Quit smoking　☐ this year　☐ > 1 year　☐ > 5years　☐> 10 years

☐ Drink Alcohol　☐ Daily　☐1-2 x's per week　☐1-2 x's per month　☐1-2 x's year

Reviewed by ____
Date______________________________