Surgical Associates of Opelousas
General Surgery

Office use only:
Sched:________________
Arrive: ________________
Ready: ________________
Nurse: ________________
Doctor: ________________
Check out: _____________
Finish: ________________

New Patient Questionnaire

Name: ___________________________________

Date: _______________

History

Why are you seeing the doctor today? ____

Who referred you to Dr Corne? ____

Who is your primary care doctor? ____

Who is your Cardiologist? ____

Past Medical History (mark next to each that you have)		
( ) Diabetes	( ) High blood pressure	( ) Heart attach
( ) Congestive Heart failure	( ) Stroke	( ) Hepatitis
( ) Kidney failure	( ) Hyperthyroidism	( ) Hypothyroidism
( ) Emphysema	( ) Asthma	( ) Pneumonia
( ) Ulcers	( ) Reflux	( ) Bleeding problems
( ) Problems with surgery	( ) History of blood clots	( ) History of cancer
( ) Atrial Fibrillation	( ) Chest pain	( ) Elevated Cholesterol
( ) Sleep Apnea	( ) Arthritis	( ) Blood Clots
( ) On dialysis?	( ) How long on dialysis?	
( ) List any others?		

Past Surgical History (mark nex to surgeries that you have had)		
( ) Appendectomy	( ) Gall bladder	( ) Hysterectomy
( ) C-section	( ) Breast Biopsy	( ) Hemorrhoidectomy
( ) Heart Surgery	( ) Pacemaker Placement	( ) Back surgery
( ) Neck surgery	( ) Colonoscopy	( ) EGD
( ) List all others		

List all medication allergies:

Circle all that apply to you

General/Constitutional
Recent weight change
Fever/chills
Fatigue
Night sweats

Skin and Hair
Rashes/sores
Skin Cancers/melanoma
Hair loss
Lumps under skin

Endocrine
Diabetes
Thyroid Disease
High Blood Pressure

Ears, Nose & Throat
Glasses/contacts
Double vision
Hearing loss
Difficulty swallowing
Ringing in the ears
Pain or stiffness in the neck
Voice changes/hoarseness

Lungs
Shortness of breath
Emphysema or chronic bronchitis
Asthma or wheezing
Congestive heart failure
Persistent cough
Pneumonia

Heart and Blood Vessels
Heart attacks
Chest pain
Heart murmur
Heart surgery
Irregular heart beat
Swelling in feet
Blood clots

Gastrointestinal
Heartburn
Ulcer disease
Jaundice
Hepatitis
Colitis
Irritable bowel syndrome
Constipation
Diarrhea
Blood in stool
Hemorrhoids
Abdominal pain
Crohns' Disease

Musculoskeletal
Arthritis
Joint Pain, stiffness or swelling
Decreased strength
Bone disease
Osteoporosis
Broken Bones
Back pain/back surgery

Neurological
Headaches
Dizziness/fainting
Weakness or tingling of arms/legs
History of head injury

Blood
Anemia
Blood Transfusion (if yes when/why)

Infections
Any serious infections
Childhood illnesses ☐measles ☐mumps
☐chicken pox
Last tetanus shot

For Women Only
Abnormal bleeding or discharge
Prior gynecological surgery
Pain during intercourse
Kidney stones
Urinary tract infections
Sexually transmitted diseases (gonorrhea, syphilis, herpes, venereal warts, AIDS, HIV, etc.)
Age at time of first menstrual period

Number of pregnancies
Number of live births
Did you breast feed your children? _______
How long did you breast feed if yes?
Date of your last menstrual period .

Breast
Pain
Nipple discharge
Lumps
Change in size
Prior breast surgery

For Men Only
Kidney stones
Prostate disease
Difficulty urinating
Vasectomy
Sexually transmitted diseases (gonorrhea, syphilis, herpes, venereal warts, AIDS, HIV, etc.

Medications

List all medications that you currently use			
Name	Dosage	Frequency	Indication

Social/Family History

Family History (Please indicate if any relative has had)		
Disease	Relationship	Age
Hypertension		
Diabetes		
Heart disease		
Stroke		
Kidney failure / dialysis		
Breast Cancer		
Colon Cancer		
Ovarian Cancer		
Lung Cancer		
Other		

Social History:

1. What type of work do you do? ______________________________

   ☐ Retired ☐ Disabled

2. Do you smoke? ☐Yes ☐No Have you ever smoked ? ☐ Yes ☐ No

   If yes how many packs a day? _________________

   How long have you or did you smoke? ___________

3. Do you drink alcohol? ☐Yes ☐ No How many drinks a day? _____________

4. Have you EVER used any street drugs such as cocaine, marijuana, etc? ☐ Yes ☐No Please describe? ____

Patient Signature: ____ Date: ___________________