

NEWTON-WELLESLEY SURGEONS, INC.

1. Name _____ Date of Birth _____
Primary M.D. _____ Referring M.D. _____

2. Reason For Visit _____

3. Please list medical history

Medical Problem or Disease	Year Diagnosed	Physician
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

4. Please list surgical history

Operation or reason for hospitalization	Year	Hospital	Physician
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

5. Please list all current medications and dosage

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

6. Please list any drug allergies

- 1. _____
- 2. _____
- 3. _____

7. Please list any of the following:

Smoking (how much?) _____
Alcohol (how much?) _____
Occupation _____

8. Family History of Cancer

Who? _____

Please complete reverse side.

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Have you recently had any of the following symptoms or medical problems?

General	Anemia	YES	NO	Abdomen	Nausea	YES	NO	
	Fevers				Vomiting			
	Night Sweats				Diarrhea			
	Weight Loss				Constipation			
	Swollen Glands				Change in Bowel Habits			
Breasts	Lumps				Hemorrhoids			
	Discharge				Hepatitis (jaundice)			
	Pain				Heartburn			
Ears	ringing				Ulcers			
	Hearing Loss				Skin	Rash		
	Infections					Easy Bruising		
Eyes	Blurring			Poor Healing				
	Double Vision			Itching				
	Cataracts			Urinary	Increased Frequency			
	Glaucoma				Burning			
Nose and Sinus	Infections				Bloody Urine			
	Bleeding				Kidney Stones			
Throat	Infections			Infections				
	Hoarseness			Bone/Joints	Pain			
	Trouble Swallowing				Stiffness			
Endocrine	Thyroid Problems				Swelling			
	Cold Intolerance				Limited Motion			
	Heat Intolerance			Nerves	Seizures			
	Excessive Thirst				Tremor			
Lungs	Cough				Fainting/Blackouts			
	Sputum (phlegm)				Localized Numbness			
	Coughing up blood				Localized Weakness			
	Short of Breath				Dizziness			
	Wheezing				Trouble Speaking			
Heart	Chest Pain				Trouble Walking			
	Short of Breath				Vertigo			
	Palpitations				Difficulty Sleeping			
	Ankle Swelling				Anxiety			
Vascular	Leg Cramps			Depression				
	Varicose Veins							
	Phlebitis							

Please explain any positive or abnormal responses: _____

Reviewed By _____ Date _____