DALLAS SURGICAL GROUP
Peter D. Beitsch, M.D., FACS

Name_____ Date_____

Problem you are here for:

_____

_____

_____

_____

_____

Please answer *all* of the following questions to the best of your ability:

Have you ever been diagnosed with any of the following?

Basal Cell Carcinoma _____
If yes, where on your body? _____ When? _____

Squamous Cell Carcinoma _____
If yes, where on your body? _____ When? _____

Melanoma _____
If yes, where on your body? _____ When? _____

Have you had any previous severe sunburns? _____ YES _____ NO

Has anyone in your family been diagnosed with **melanoma**? _____
If yes, who? _____
_____

Name of your Obstetrician/Gynecologist _____

Name of your Primary Care Doctor _____

Pharmacy Name _____

Address and/or Phone #_____

Initial _____

Name _____

PAST SURGERY (Operations)
Please list in chronological order. Check here if no prior surgery _____

Date Operation Hospital/Doctor

_____
_____
_____

PAST MEDICAL HISTORY
Have you ever had (check all that apply):

____ High Blood Pressure	____ Diabetes	____ Stroke	____ Asthma
____ Angina (chest pain)	____ Kidney Disease	____ Seizure	____ Cancer
____ Heart Attack	____ Heart Failure	____ Emphysema	____ Hepatitis
____ Other Heart Problems	____ Organ Transplant		

MEDICATIONS
Please list all the medications you take. Include aspirin and over the counter medications.
Check here if none _____

Name Dosage # of times per day

_____
_____
_____
_____
_____
_____
_____
_____

VITAMINS/HERBAL SUPPLEMENTS
Some vitamins and herbal supplements can cause increased bleeding during and after surgery.
Please note if you take any of the following:

____Fish Oil/Omega 3	____Aspirin/Advil	____Ginkgo Biloba
____Garlic	____Ginseng	____Vitamin E
____Ephedra	____Echinacea	____St. John's Wort
____Valerian	____Kava	

ALLERGIES
Please list all of your allergies. Check here if none _____

Substance Effect

_____
_____
_____

SOCIAL HISTORY
Do you smoke? _____ How much? _____ For how long? _____
Do you drink? _____ How much? _____ For how long? _____

Initial _____

Name _____

REVIEW OF SYMPTOMS

Are you *currently* experiencing any of these symptoms (please check all that apply)?

Constitutional Symptoms

___ Fever ___ Night Sweats ___ Weight Loss

Eyes

___ Glaucoma ___ Cataracts

Ear, Nose, Mouth and Throat

___ Ear Problems ___ Sinus Problems ___ Bleeding Gums
___ Painful Swallowing ___ Change in voice

Cardiovascular

___ High Blood Pressure ___ Blood Clot in Legs ___ Chest Pain
___ Heart Attack ___ Leg Pain when Walking ___ Heart Murmur
___ Irregular Heart Beats ___ Congestive Heart Failure

Respiratory

___ Asthma ___ Emphysema

Gastrointestinal

___ Difficulty Swallowing ___ Peptic Ulcers ___ Nausea/Vomiting
___ Liver Disease ___ Hepatitis

Genitourinary

___ Kidney Stones ___ Kidney Infection
Men: Difficulty Urinating/enlarged prostate ___ Women: Abnormal Bleeding ___

Musculoskeletal

___ Arthritis ___ Osteoporosis

Skin

___ Psoriasis ___ Skin Cancer ___ Melanoma

Breast

___ Breast Lumps ___ Nipple Discharge ___ Breast Pain

Neurological

___ Headaches ___ Stroke ___ Seizures
___ Migraines

Psychiatric

___ Depression

Endocrine

___ Diabetes ___ Temperature Intolerance

Hematologic/Lymphatic

___ Anemia ___ Blood Clotting Problem ___ Daily Aspirin

Allergy/Immune System

___ Immune Deficiency ___ Latex Allergy

Initial _____

Name _____

FAMILY HISTORY

Please include such items as:

Lung Cancer	Breast Cancer	Other Cancer	Heart Attack
Colon Cancer	Prostate Cancer	Kidney Disease	High Blood Pressure
Melanoma	Ovarian Cancer	Diabetes	Strokes

	Living/Age	Deceased/Age	Medical Problems
Parents:			
Father			
Mother			
Brothers:			
Sisters:			
Children:			

PATIENT SIGNATURE _____ DATE _____

Initial _____