**Essex Surgical Associates**

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Today’s Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Personal History Form** *(for patient to fill out)*

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_

PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES:   Y \_\_\_\_ N \_\_\_\_ Drugs, Food, Others (describe reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LATEX Sensitive:  Y \_\_\_\_ N \_\_\_\_        Height: \_\_\_\_ (ft) \_\_\_\_(in)   Weight: \_\_\_\_\_\_ (lbs)

**Reason for Today’s Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of Medical Conditions/Illnesses: *(circle if YES)***

**NONE**    Heart Disease (Type: angina, heart attack, atrial fibrillation)     Stroke or TIA

High Blood Pressure    High Cholesterol    Diabetes    Thyroid Disorder (Type: hyper, hypo)

Lung Disease (Type:  COPD, emphysema, asthma, sleep apnea)     Kidney Disease

Bleeding Disorder    HIV or AIDS    Hepatitis    TB    Peptic Ulcer (stomach ulcer)

Breast Disease (list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)    Cancer (list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of Prior Surgeries: *(circle if YES)***

**NONE**    Appendectomy    Tonsillectomy    Gallbladder    Hysterectomy    Heart Surgery    Pacemaker

Back Surgery    Joint Surgery    Hernia Surgery    Weight Loss Surgery

Other surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ever had a Colonoscopy? Y \_\_ N \_\_   Date & Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had a flu shot recently?**     Y\_\_\_        N\_\_\_    Month/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of Medications & Supplements** (Prescription & Over the Counter) (Name, Dose, Frequency):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy (local)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: *(in a blood relative & list relationship to the patient please)* NONE**

Cancer (list type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IBD *(Ulcerative Colitis or Crohn’s)*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Polyps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Occupation:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Still working: \_\_\_\_ Retired: \_\_\_\_ Disabled: \_\_\_\_

Marital Status (circle): Married – Single – Divorced – Widowed  Regular Exercise:  Y \_\_\_ N \_\_\_

How much alcohol do you drink each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much do you smoke each day (or when did you quit)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which recreational (non-prescribed) drugs do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much caffeine do you have each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN**:  Last Menstrual Period \_\_\_\_\_\_\_\_\_\_ Age Menses Started \_\_\_\_\_\_\_\_\_\_  Age @ Menopause \_\_\_\_\_\_\_\_\_\_

Date & Results:  Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Pap Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age @ 1st Delivery\_\_\_\_\_\_ # of Pregnancies\_\_\_\_\_\_\_\_ # of Births \_\_\_\_\_\_\_\_\_  Did you breastfeed: Y \_\_\_\_\_ N \_\_\_\_\_

**Review of Systems: *(circle if YES or choose “NONE” option if NO symptoms currently/recently)***

* Constitutional:  NONE - Loss of Appetite - Weight Gain/Loss – Fatigue - Night Sweats – Fevers - Chills
* Hematology:  NONE - Bleeding disorder - Easy Bruising - Multiple Blood Transfusions
* Infectious Disease:  NONE - Hepatitis – TB – HIV/AIDS
* Psychiatric:  NONE - Insomnia – Depression – Anxiety – Memory Loss
* Neurological:  NONE - Seizures – Headaches - Numbness or Paralysis of extremities (temporary/permanent)
* HEENT:  NONE - Dentures - Hearing Problems – Sinusitis - Wear Glasses - Blurry or Double Vision
* Cardiovascular:  NONE - Chest Pain - Heart Palpitations - Take Antibiotics for Dental Procedures
* Peripheral Vascular: NONE - Foot Pain at Rest – Non Healing Sores – Leg cramping
* Pulmonary:  NONE - Shortness of Breath with Exercise – Wheezing - Chronic Cough
* Gastro Intestinal:  NONE - Nausea - Abdominal Pain – Constipation – Diarrhea - Dark Stools - Blood in Stool
* Genital Urinary:  NONE - Kidney Stones – Burning with Urination – Blood in Urine – Difficulty Voiding
* Skin:  NONE - Rashes – Jaundice – Eczema – Psoriasis
* Rheum: NONE – Bone Pain – Joint Pain