Coastal Thoracic Surgical Associates

Affiliated with New Hanover Regional Medical Center

Dr. Ivan David, M.D.
Dr. Peter Kane, M.D.
Dr. Howard F. Marks, Jr., M.D.

PATIENT HISTORY FORM - PART 1

Patient History

Patient Name _____ Date _____

Date of Birth _____ Age _____

Cigarette/Cigar/Pipe Use? ◦ Past ◦ Present Number per Week _____

Alcohol Consumption ◦ Past ◦ Present Number Drinks per Week _____

Caffeine (tea, cola, coffee) How Much per Week _____

Past Medical History

Hospitalization	Dates of Illness	Where Treated

Family History

◦ Tuberculosis ◦ High Blood Pressure ◦ Kidney Disease

◦ Emphysema ◦ Stroke ◦ Cancer

◦ Asthma ◦ Diabetes ◦ Blood Disorder

◦ Heart Disease ◦ Sickle Cell Anemia ◦ Epilepsy/Seizure

◦ Bleeding Tendency ◦ Nervous Disorder ◦ Suicide

◦ Other _____

◦ Allergies Please Indicate any Drugs or Substances You May be Allergic to _____

_____

OR: Initial the Following: _____ I am not allergic to any drugs or substances that I know of.

Please print and complete this form. Bring it to your appointment or fax it to us at 910.251.3760.

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PATIENT HISTORY FORM - PART 2

Patient's Name _____ Date of Birth _____

Please Review the Following List of Medical Problems and Circle the Appropriate Answer.

Constitutional Symptoms

Good general health lately	° No	° Yes
Recent weight change	° No	° Yes
Fever	° No	° Yes
Fatigue	° No	° Yes
Headaches	° No	° Yes

Eyes

Eye disease or injury	° No	° Yes
Wear glasses/contact lens	° No	° Yes
Blurred or double vision	° No	° Yes
Glaucoma	° No	° Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	° No	° Yes
Earaches or drainage	° No	° Yes
Chronic sinus problems or rhinitis	° No	° Yes
Nose Bleeds	° No	° Yes
Mouth sores	° No	° Yes
Bleeding gums	° No	° Yes
Bad breath or bad taste	° No	° Yes
Sore throat or voice change	° No	° Yes
Swollen glands in neck	° No	° Yes

Cardiovascular

Heart trouble	° No	° Yes
Chest pain or angina pectoris	° No	° Yes
Palpitation	° No	° Yes
Shortness of breath while walking or lying flat	° No	° Yes
Swelling of feet, ankles or hands	° No	° Yes

Respiratory

Chronic or frequent coughs	° No	° Yes
Spitting up blood	° No	° Yes
Shortness of breath	° No	° Yes
Asthma or wheezing	° No	° Yes

Musculoskeletal

Joint pain	° No	° Yes
Joint stiffness or swelling	° No	° Yes
Weakness of muscles or joints	° No	° Yes
Muscle pain or cramps	° No	° Yes
Back pain	° No	° Yes
Cold extremities	° No	° Yes
Difficulty in walking	° No	° Yes

Gastrointestinal

Loss of appetite	° No	° Yes
Change in bowel movements	° No	° Yes
Nausea or vomiting	° No	° Yes
Frequent diarrhea	° No	° Yes
Painful bowel movements or constipation	° No	° Yes
Rectal bleeding or blood in stool	° No	° Yes
Abdominal pain or heartburn	° No	° Yes
Peptic ulcer (stomach or duodenal)	° No	° Yes

Genitourinary

Frequent urination	° No	° Yes
Burning or painful urination	° No	° Yes
Blood in urine	° No	° Yes
Change in force or strain when urinating	° No	° Yes
Incontinence or dribbling	° No	° Yes
Kidney Stones	° No	° Yes
Sexual difficulty	° No	° Yes
Male		
Testicle pain	° No	° Yes
Female		
Pain with periods	° No	° Yes
Irregular periods	° No	° Yes
Vaginal discharge	° No	° Yes
Number of pregnancies	_____	
Number of miscarriages	_____	
Date of last Pap smear	_____	

Integumentary (skin, breast)

Rash or itching	° No	° Yes
Change in skin color	° No	° Yes
Change in hair or nails	° No	° Yes
Varicose veins	° No	° Yes
Breast pain	° No	° Yes
Breast lump	° No	° Yes
Breast discharge	° No	° Yes

Neurological

Frequent or recurring headaches	° No	° Yes
Light headed or dizzy	° No	° Yes
Convulsions or seizures	° No	° Yes
Numbness or tingling sensations	° No	° Yes
Tremors	° No	° Yes
Paralysis	° No	° Yes
Stroke	° No	° Yes
Head injury	° No	° Yes

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PATIENT HISTORY FORM - PART 3

Patient's Name _____ Date of Birth _____

Hematological/Lymphatic

Slow to heal after cuts	° No	° Yes
Bleeding or bruising tendency	° No	° Yes
Anemia	° No	° Yes
Phlebitis	° No	° Yes
Past transfusion	° No	° Yes
Enlarged glands	° No	° Yes

Endocrine

Glandular or hormone problem	° No	° Yes
Thyroid disease	° No	° Yes
Diabetes	° No	° Yes
Excessive thirst or urination	° No	° Yes
Heat or cold intolerance	° No	° Yes
Skin becoming drier	° No	° Yes
Change in hat or glove size	° No	° Yes

Psychiatric

Memory loss or confusion	° No	° Yes
Nervousness	° No	° Yes
Depression	° No	° Yes
Insomnia	° No	° Yes

Allergic/Immunologic

History of skin reaction to:

Penicillin or other antibiotics	° No	° Yes
Morphine, Demerol or other narcotics	° No	° Yes
Novocaine or other anesthetics	° No	° Yes
Aspirin or other pain remedies	° No	° Yes
Tetanus antitoxin or other serums	° No	° Yes
Iodine, methiolate or other antiseptic	° No	° Yes

Other drugs/medications _____

Known food allergies _____

Current Medications

Primary Pharmacy Phone Number _____

Name	Strength	Times per day
Example: Lasix	40 mg	Daily

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