SURGICAL ASSOCIATES OF KINGSPORT, INC.

Medical Profile

Name_____Date_____Date of Birth_____

Address_____
Phone# _____
What symptoms brought you to our office?_____
Please complete both sides and make a list of specific questions or concerns about your symptoms.
Year of last tetanus shot?_____ Weight_____ Height_____
Do you use tobacco?____ How much? _____ What kind?_____
What age did you start using tobacco?_____ Have you previously used tobacco products?_____
Do you drink alcoholic drinks?_____ What kind?_____
How often?_____How much?_____ Do you use illicit drugs?_____

Doctor that sent you to our practice_____

Medical Doctor_____Other Physician(s) caring for you?_____

PAST HOSPITALIZATIONS AND SURGERY

WHEN	WHERE	WHY

PERSONAL PAST MEDICAL HISTORY

_____
_____
_____
_____

FAMILY HISTORY: CANCER, HEART DISEASE, DIABETES OR TUBERCULOSIS

DISEASE	RELATIONSHIP

CURRENT MEDICATIONS

DRUG	DOSE	HOW OFTEN

Surgical Associates of Kingsport, Inc. has my permission to leave messages on my answering machine.
Yes__ No__ Patient's or Guarantor's Signature_____

To whom may we release your medical information: (spouse, children, doctor, relatives):

_____

Patient's or Guarantor's Signature_____

Medical Profile2

GENERAL Y N

Weight Change (gain or loss) ☐ ☐
Fever/Chills ☐ ☐
Night Sweats ☐ ☐
Dizziness ☐ ☐

ENDOCRINE

Heat/cold intolerance ☐ ☐
Thyroid problems ☐ ☐
Neck surgery/irradiation ☐ ☐
Diabetes ☐ ☐
Increased urination, thirst, or hunger ☐ ☐

EYES

Visual disturbance ☐ ☐

EARS, NOSE, AND THROAT

Hearing difficulty ☐ ☐
Ringing in ears ☐ ☐
Nose bleed ☐ ☐
Hoarseness ☐ ☐
Sinusitis ☐ ☐
Awkwardness, room spinning, dizziness ☐ ☐

GASTROINTESTINAL

Nausea/retching/vomiting ☐ ☐
Vomiting blood ☐ ☐
Blackened stools ☐ ☐
Difficulty swallowing ☐ ☐
Indigestion/heartburn ☐ ☐
Abdominal pain ☐ ☐
Abdominal swelling ☐ ☐
Jaundice (Yellow skin) ☐ ☐
Bloody stools ☐ ☐
Diarrhea ☐ ☐
Constipation ☐ ☐
Hernia ☐ ☐
Hemorrhoids ☐ ☐
Ulcers ☐ ☐
Gallbladder ☐ ☐
Disease ☐ ☐
Pancreatitis ☐ ☐

HEART

Shortness of breath with minimal exercise ☐ ☐
Shortness of breath during sleep ☐ ☐
Chest discomfort/pain ☐ ☐
Palpitation/irregular heartbeats ☐ ☐
Blackout spells ☐ ☐
Leg-swelling ☐ ☐

	Y	N
Phlebitis, varicose veins, leg clots	☐	☐
Leg/hip pain with exercise	☐	☐
High blood pressure	☐	☐
Previous heart disease	☐	☐
Rheumatic heart disease	☐	☐

GENITOURINARY

Urinary frequency ☐ ☐
Urinary urgency ☐ ☐
Flank Pain ☐ ☐
Frequent night urination ☐ ☐
Bloody urine ☐ ☐
Stones ☐ ☐
Urinary flow/stream abnormality ☐ ☐
Discharge ☐ ☐
Testicular mass/pain ☐ ☐
Impotence ☐ ☐
Difficulty with erection ☐ ☐

GYNECOLOGICAL

Birth Control ☐ ☐
Last period _____
Pelvic pain ☐ ☐
Vaginal discharge ☐ ☐
Number of children____
Vaginal bleeding ☐ ☐

BREASTS

Pain ☐ ☐
Lump ☐ ☐
Discharge ☐ ☐

SKIN

Moles ☐ ☐
Rash ☐ ☐
Itching ☐ ☐
Bleeding ☐ ☐
Nonhealing areas ☐ ☐

NEUROLOGIC

Headache ☐ ☐
Epilepsy/seizures ☐ ☐
Stroke ☐ ☐
Temporary stroke ☐ ☐

LUNGS

Breathlessness ☐ ☐
Cough, dry ☐ ☐
Cough, productive ☐ ☐
Wheezes, asthma ☐ ☐
Tuberculosis/positive Skin test ☐ ☐

	Y	N
Pneumonia	☐	☐
Smoking history	☐	☐
Work inhalation	☐	☐

HEMATOLOGIC

Excessive bleeding after cuts or surgery ☐ ☐
Anemia ☐ ☐
Blood thinners ☐ ☐

MUSCULOSKELETAL

Joint stiffness
Joint pain
Joint swelling

ALLERGIES

Antibiotics

_____
_____
_____

Reaction

_____
_____
_____

Other Drugs

_____
_____
_____

Reaction

_____
_____
_____

Food

_____
_____

Reaction

_____
_____