MONTANY
Matt 25:40
Thoracic, Vascular & General Surgery

What is the reason for your visit today? _____

_____

Have you had any imaging for this problem? (X-ray, CT scan, PET scan, ultrasound, mammogram, etc) YES / NO

If yes, what type of imaging? _____

Where was it done? _____

If you are **female** and over the age of **40**:

Have you ever had a **mammogram**? YES / NO
If so, when/where? _____
Who ordered it? _____
What were the results? _____
Do you have breast cancer in your family? _____

If you are either **male or female** and over the age of **45:**

Have you ever had a **colonoscopy**? YES / NO
If so, when/where? _____
Who did it _____
What were the results? _____
Do you have colon cancer in your family? _____

If you are either **male or female** and between **55-77** (80)**:**

Do you/did you **smoke cigarettes**? YES / NO
If so, for how many years? _____ ≥ 30 pk/yr
When did you start? _____
How many packs per day on average? _____
If you quit, when? _____ < 15 yr ago
Do you/did you have lung cancer? _____
Do you vape? _____

Office Use

screening colonoscopy – Z12.11
pers hist colon polyps – Z86.010
fam hist colon cancer – Z80.0
screening breast eval – Z12.39
hist tob abuse – Z87.891
initial visit – G0296

MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI

PATIENT INFORMATION

Date _____

Patient Information

Name _____ Soc Sec Number _____

Date of Birth _____ Age _____ Sex _____

Race _____ Religion _____

Marital Status _____ Maiden/Other Name _____

Address _____

City/State/Zip _____

Primary Phone _____ Secondary Phone _____

Email Address _____

Family Doctor _____

Employer Name _____

Address _____

City/State/Zip_____ Phone _____

Primary Emergency Contact

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Secondary Emergency Contact

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Office Use

Height _____ BP _____ Resp _____

Weight _____ Pulse _____ Temp _____

Are you having pain today? **YES / NO**

If so, where? _____

How bad is the pain, on a scale of 1 to 10? **1 2 3 4 5 6 7 8 9 10**

Are you allergic to any medications or products? _____

(such as latex, shellfish, or iodine) _____

What medications are you currently taking? _____

_____

_____

_____

_____

What pharmacy do you prefer to use? _____

How far did you get in school?

NONE
HIGH SCHOOL
SOME COLLEGE
COLLEGE DEGREE
POST-GRADUATE DEGREE

Do you feel unsafe at home? **YES / NO**

Do you have an Advance Directive? **YES / NO**

(a legal statement of a person's wishes regarding possible future medical treatment)

Do you have any learning difficulties?

No	**Fatigue**	**Poor reading**
Illness	**Money problems**	**Poor memory**
Poor thinking	**Poor hearing**	**Poor vision**
Cultural barrier	**Language barrier**	**Other**
Desire/Motivation	**Poor math skills**	
Poor concentration	**Poor health knowledge**	
Emotional state	**Poor problem solving**	

If you are at least 65, have you fallen in the past year? **YES / NO**

Surgical History

	Procedure	Doctor/Where	Date
1.			
2.			
3.			
4.			
5.			
6.			

Medical History (check all that apply)

- ○ Anemia
- ○ Arthritis
- ○ Cancer (type) _____
- ○ Diabetes
- ○ Gastrointestinal Problems (ex. GERD, acid reflux)
- ○ High Blood Pressure
- ○ Heart Disease
- ○ Kidney Disease
- ○ Lung Disease
- ○ Seizures
- ○ Stroke
- ○ Thyroid Disease
- ○ Other _____

Alcohol / Substance Abuse

	Never	Past	Current
Alcohol:	_____	_____	_____
Sub Abuse:	_____	_____	_____

Family History

	Mother	Father	Sister	Bother	GM (m)	GM (p)	GF (m)	GF (p)
Cancer (type)								
Diabetes								
High Blood Press								
Heart Disease								
Kidney Disease								
Lung Disease								
Stroke								

REVIEW OF SYSTEMS

Please check all of the following items that apply to you.

CONSTITUTIONAL

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats

EYES

- ☐ Visual Changes

EARS, NOSE, THROAT

- ☐ Ear Ache
- ☐ Nasal Congestion
- ☐ Sore Throat

RESPIRATORY

- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Coughing Up Blood

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Irregular Heartbeat

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain

GENITOURINARY

- ☐ Blood in Urine

HEMATOLOGIC

- ☐ Easy Bruising
- ☐ Swollen Glands

ENDOCRINE

- ☐ Excessive Thirst
- ☐ Cold Intolerance
- ☐ Heat Intolerance

IMMUNOLOGIC

- ☐ Frequent Infections

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Bone/Joint Pain
- ☐ Muscle Weakness

SKIN

- ☐ Rash
- ☐ Skin Lesion

NEUROLOGICAL

- ☐ Seizure

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression

Breast History

Patient Name: _____

1. Race

- o African American
- o Asian/Pacific Islander
- o Caucasian
- o Hispanic/Latino
- o Other/Prefer not to answer

2. Do you drink alcohol?

- o Yes
- o No

3. How old were you when first started your period?

Age _____

4. How old were you when you had your first child?

Age _____

- o I've never had children

5. How many times have you been pregnant? _____

6. Number of viable (living) offspring at birth _____

7. Number of abortions (including spontaneous and induced) _____

8. When was your last menstrual period?

Date ___/____/_____

Age at menopause _____

9. Which type of birth control are you currently using?

Name _____

- o I am not currently on birth control medication

10. Have you had any hormone replacement therapy within the last 5 years?

- o Yes
- o No

11. Have you ever been exposed to any form of radiation?

- o Yes
- o No

12. Have you have breast problems before?

- o Yes
- o No

13. What were your previous mammogram results?

- o Normal
- o Abnormal

14. Have you ever been diagnosed with *breast cancer*?

- o Yes
- o No

15. Do you have any family history of *breast* or *ovarian* cancer? If so, what relative and which type?

Breast or Ovarian	Relationship