NORTHSIDE CHEROKEE SURGICAL ASSOCIATES
900 Towne Lake Parkway, Suite 412 • Woodstock, GA 30189
770-924-9656 • Fax 770-852-7574

PATIENT INFORMATION

Patient Name: _____

Self Medical History:

Please indicate whether YOU have had any of the medical illnesses listed below

Sensory Defects
- Loss of Hearing or Deaf ☐ Yes ☐ No
- Loss of Vision or Blind ☐ Yes ☐ No

Respiratory (Lung or Breathing Problems)
- Asthma / Wheezing ☐ Yes ☐ No
- Emphysema / COPD ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No

Cardiac (Heart Problems)
- Fast Heart Rate Requiring Therapy ☐ Yes ☐ No
- Heart Attack / Angioplasty / CABG ☐ Yes ☐ No
- Heart Failure ☐ Yes ☐ No
- Heart Murmur ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- High Cholesterol ☐ Yes ☐ No

Vascular (Circulation Problems)
- Aneurysm ☐ Yes ☐ No
- Peripheral Artery Disease ☐ Yes ☐ No
- Varicose veins ☐ Yes ☐ No
- Wounds or Sores ☐ Yes ☐ No

Gastrointestinal (GI or Abdominal Problems)
- Gall Bladder Problems ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- Liver Disease ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No
- Hemorrhoids ☐ Yes ☐ No
- Anal Rectal ☐ Yes ☐ No
- GI Bleeds ☐ Yes ☐ No
- Hernia ☐ Yes ☐ No

Renal (Kidney Problems)
- Kidney Failure ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No
- Kidney Stones ☐ Yes ☐ No

Immunologic / Infectious Disease
- AIDS ☐ Yes ☐ No
- HIV ☐ Yes ☐ No
- Auto-Immune (e.g. Lupus) ☐ Yes ☐ No

Endocrine
- Diabetes ☐ Yes ☐ No
- Low Blood Sugar ☐ Yes ☐ No
- Thyroid Problems ☐ Yes ☐ No

Musculoskeletal (Bone, Joint, or Muscle Problems)
- Arthritis ☐ Yes ☐ No
- Osteoporosis ☐ Yes ☐ No

Neurological (Brain or Nerve Problems)
- Headaches / Migraines ☐ Yes ☐ No
- Parkinson's / Tremor ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- TIA ☐ Yes ☐ No

Mental Health
- Alzheimer's / Dementia ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Mental Illness ☐ Yes ☐ No

Hematologic (Blood Problems)
- Anemia ☐ Yes ☐ No
- Bleeding Disorder ☐ Yes ☐ No
- Clotting Problems ☐ Yes ☐ No

Oncologic (Cancer)
- If yes, what type? _____
- Chemotherapy ☐ Yes ☐ No
- Radiation Therapy ☐ Yes ☐ No

Breast
- Breast Cancer/Mass ☐ Yes ☐ No

Skin
- Skin Cancer ☐ Yes ☐ No

Other Medical Illnesses (please list)

_____
_____
_____
_____
_____

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Family Medical History:

Please indicate whether any of your **BLOOD RELATIVES** have any of the medical illnesses listed below.

- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Kidney Problems _____
- ☐ DVT _____
- ☐ Bleeding Disorders _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Throat Cancer _____
- ☐ Other Cancer _____

Previous surgeries or hospitalizations:

Reason for Hospitalization	Date	Hospital Name	Any Complications

Social History

Do you Smoke? ..... ☐ Yes ☐ No
How long? _____
How many cigarettes per day? _____
Do you drink Alcohol? ..... ☐ Yes ☐ No
What type? _____
How often? _____

Do you use drugs? ..... ☐ Yes ☐ No
Do you Work? ..... ☐ Yes ☐ No
What is your job? _____
Retired? _____
Disability? _____

Primary Care Physician _____
Heart Doctor (Cardiologist) _____
Pharmacy _____

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