ATLANTA
LIVER & PANCREAS
SURGICAL SPECIALISTS

| DEMOGRAPHIC INFORMATION | | |
|---|---|---|
| Name: (First) (Middle) (Last) | | |
| Preferred Name: | Maiden Name: | Religion (optional): |
| Date of Birth: | Age: | Place of Birth: |
| Home Phone: | Cell Phone: | |
| Do You Have Children? ☐ Yes ☐ No | If yes, what are their names and ages? | |
| Spouse/Partner Name: | | |
| Do You Have an Advance Directive? ☐ Yes* ☐ No | If yes, please provide a copy to our office | |
| REASON FOR YOUR VISIT: | | |

| SOCIAL HISTORY | | | | |
|---|---|---|---|---|
| Smoking History | ☐ Never ☐ Occasional ☐ Quit ☐ Daily | _____ packs/day | How long? _____ | Date Quit _____ |
| Alcohol History | ☐ Never ☐ Social ☐ Quit ☐ Daily | _____ drinks per day/wk | How long? _____ | Date Quit _____ |
| Recreational Drugs | ☐ Never ☐ Past ☐ Active | | | |
| Residential Status: | ☐ Alone ☐ Lives with family ☐ Lives with friends/roommates ☐ Assisted Living ☐ Nursing Home | | | |
| Highest Level of Education: | ☐ Elementary ☐ Middle School ☐ High School Diploma/GED ☐ College/Undergraduate ☐ Post-graduate | | | |
| Occupation: | | | | |
| Hobbies: | | | | |
| Travel History (please list places & dates of travel outside of the USA): | | | | |

| MEDICAL CARE TEAM | |
|---|---|
| Oncologist: | Practice / Location: |
| Gastroenterologist: | Practice / Location: |
| Cardiologist: | Practice / Location: |
| Endocrinologist: | Practice / Location: |
| PCP: | Practice / Location: |
| Dentist: | Practice / Location: |
| Other MD: | Practice / Location: |

| ALLERGIES | |
|---|---|
| Do you have any medication allergies? ☐ Yes ☐ No | Do you have any environmental allergies? ☐ Yes ☐ No |
| *Please list all allergies below (include medications, tape, latex, other). Please list *food allergies* in Nutrition History.* | |
| **Name of Medication / Allergy** | **Type of Reaction** |
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# MEDICAL HISTORY

Name: DOB:

| CURRENT MEDICATION LIST<br>*Please list all current medications in the list below. Dietary supplements should be included in Nutrition History.* | | |
|---|---|---|
| **Name of Medication** | **Dosage** | **Frequency** |
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Do you take Aspirin or any other non-steroidal anti-inflammatories (NSAIDS- i.e., Ibuprofen, Motrin, Plavix, Lovenox)? ☐ Yes ☐ No
*Please list all NSAIDs below.*

Have you ever been a patient at the Northside Hospital Pain Clinic? ☐ Yes ☐ No

Have you ever received narcotics for pain management? ☐ Yes ☐ No
*If yes, please list any **current** pain meds below, along with medical prescriber.*

| SURGICAL HISTORY | | |
|---|---|---|
| Have you ever had any anesthesia complications? ☐ Yes* ☐ No | | |
| If yes*, describe the type of anesthesia complications: | | |
| **Type of Surgery** | **Date of Surgery** | **Complications** |
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## MEDICAL HISTORY

Name: _____ DOB: _____

| BLOOD PRODUCT TRANSFUSION HISTORY |
|---|
| Have you ever received a blood transfusion? ☐ Yes ☐ No<br>If yes, was your blood transfusion related to chemotherapy / radiation? ☐ Yes ☐ No |
| List dates of blood transfusion(s): |
| Have you ever experienced a transfusion reaction to any blood products? ☐ Yes ☐ No<br>If yes, what type of reaction did you have? |

| Other Procedures / Tests (please mark if applicable): | |
|---|---|
| **Date of COVID Vaccine*:** | ***Please provide copy of your COVID vaccine card to our staff!** |
| Date of Last Colonoscopy: | |
| Date of Last Mammogram: | |
| Date of Last Pap Smear: | |
| Date of Last Dental Exam: | |
| Date of Last Flu Vaccine: | |
| Date of last Pneumonia Vaccine: | |

## MEDICAL HISTORY

Have you ever been treated for cancer? ☐ Yes ☐ No
If yes, what type of cancer? _____
Diagnosis Date: _____
Treatment Received: _____

Please check the appropriate boxes if you have a **HISTORY** of any of the following conditions:

| √ | Year | √ | Year | √ | Year |
|---|---|---|---|---|---|
| ❑ Diabetes- Type 1<br>❑ Diabetes – Type 2 | | ❑ Genetic Mutation (BRCA I/II, ATM, PALB, etc) | | ❑ Cirrhosis | |
| ❑ High Blood Pressure | | ❑ Depression or Anxiety | | ❑ Hepatitis – Type _____ | |
| ❑ Coronary Artery Disease | | ❑ Skin disease | | ❑ Other Liver Disease | |
| ❑ History of Heart Attack | | ❑ Arthritis | | ❑ HIV or AIDS | |
| ❑ Tuberculosis | | ❑ Nerve Disorder | | ❑ Sickle Cell Disease | |
| ❑ Asthma | | ❑ Stroke | | ❑ History of Herpes Zoster | |
| ❑ Pneumonia or Emphysema | | ❑ Seizures or Epilepsy | | ❑ History of Organ Transplant | |
| ❑ Pulmonary Embolus (PE) or Deep Venous Thrombus (DVT) | | ❑ Kidney Disease | | ❑ Childhood Illnesses (ie. mumps)<br>If yes, please list:<br>_____<br>_____ | |
| ❑ Anemia | | ❑ Autoimmune Disorder | | ❑ Compromised Immune System | |
| ❑ Thyroid Disease | | ❑ Stomach Ulcer or Reflux | | ❑ Number of Pregnancies? _____ | |
| ❑ Irritable Bowel Syndrome | | ❑ Gallstones | | ❑ Other: _____ | |
| ❑ Jaundice | | ❑ | | ❑ | |

Do you currently have or have had a history of the following (please circle): VRE MRSA C-DIFF Other: _____

Name: DOB:

| REVIEW OF SYSTEMS | | | |
|---|---|---|---|
| Please check the appropriate boxes if you **CURRENTLY** have any of the following conditions: | | | |
| | √ | √ | √ |
| ***CONSTITUTIONAL*** | ❑ fatigue | ❑ weakness | ❑ fever |
| | ❑ Weight gain without trying If yes, ____lbs? | ❑ Weight loss without trying If yes, ____lbs? | ❑ body aches |
| ***EYES*** | ❑ changes in vision | ❑ glaucoma | |
| ***EARS/NOSE/THROAT*** | ❑ hearing loss | ❑ nose bleeds | ❑ sore throat |
| | ❑ difficulty swallowing | ❑ neck pain | ❑ headaches |
| | ❑ dental problems | | |
| ***BREASTS*** | ❑ lumps in breast | ❑ tenderness in breast | ❑ swelling in breast |
| ***CARDIOVASCULAR*** | ❑ chest pain | ❑ leg pain with walking | ❑ leg swelling |
| | ❑ palpitations (irregular heartbeat) | ❑ cardiac murmurs | ❑ dyspnea (shortness of breath) on exertion |
| | ❑ syncope (fainting) | | |
| ***RESPIRATORY*** | ❑ chronic cough | ❑ shortness of breath | ❑ difficulty breathing |
| | ❑ coughing up blood | ❑ wheezing | ❑ sleep apnea |
| ***GASTROINTESTINAL*** | ❑ changes in bowel habits | ❑ nausea | ❑ vomiting |
| | ❑ diarrhea | ❑ constipation | ❑ abdominal pain |
| | ❑ jaundice | ❑ eating poorly because of a decreased appetite | ❑ early satiety (feeling full) |
| | ❑ heartburn | ❑ hematemesis (vomiting blood) | ❑ bloating |
| | ❑ hematochezia (blood in stool) | ❑ melena (black stool) | ❑ light colored stool |
| | ❑ floating or oily stool | | |
| ***GENITOURINARY*** | ❑ increased urine frequency | ❑ painful urination | ❑ urinary retention |
| | ❑ blood in urine | ❑ urinary tract infection | ❑ urinary urgency |
| | ❑ urinary incontinence | ❑ testicular pain (male) | ❑ lumps in testicles or scrotum (male) |
| ***INTEGUMENT / SKIN*** | ❑ itching | ❑ nail changes | ❑ skin color changes |
| | ❑ rash | ❑ dryness | ❑ jaundice |
| ***NEUROLOGIC*** | ❑ headaches | ❑ dizziness/vertigo | ❑ numbness/tingling |
| | ❑ seizures | ❑ tremors | |
| ***MUSCULOSKELETAL*** | ❑ muscular weakness | ❑ muscle aches/pains | ❑ join pain/stiffness |
| | ❑ joint swelling | ❑ decreased range of motion | ❑ bone pain |
| ***ENDOCRINE*** | ❑ heat/cold intolerance | ❑ increased thirst | ❑ increased urination |
| | ❑ excessive sweating | | |
| ***PSYCHIATRIC*** | ❑ anxiety | ❑ depression | ❑ hallucinations |
| | ❑ suicidal thoughts | ❑ memory changes | ❑ difficulty sleeping |
| ***HEMATOLOGY*** | ❑ easy bruising | ❑ prolonged bleeding | ❑ enlarged lymph nodes |
| ***ALLERGIC-IMMUNOLOGIC*** | ❑ sinus allergy symptoms | ❑ allergic dermatitis | ❑ frequent illness |
| ***OTHER CURRENT SYMPTOMS:*** | | | |

Name: _____ DOB: _____

| NUTRITION HISTORY |
|---|
| What is your usual adult weight range? |
| Any special diet needs prescribed by your physician? ☐ Yes ☐ No If yes, please describe: |
| Do you take pancreatic enzymes? ☐ Yes ☐ No |
| Do you avoid any food groups? ☐ Yes ☐ No If yes, please list: |
| Do you follow a certain diet (ie- vegetarian, paleo, etc)? ☐ Yes ☐ No If yes, please list: |
| Have you ever been on a weight reduction diet? ☐ Yes ☐ No |
| Do you have any food allergies? ☐ Yes ☐ No If yes, please list: |
| Do you have any food intolerances (ie- lactose, gluten, etc)? ☐ Yes ☐ No If yes, please list: |

*Please list your dietary supplements below*

| Name of Dietary Supplement | Dosage | Frequency |
|---|---|---|
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| FAMILY / GENETICS HISTORY |
|---|
| Have you ever met with a genetic counselor? ☐ Yes ☐ No |
| Have you ever had genetic testing done? ☐ Yes ☐ No If yes, when did you have testing? _____ |
| If genetic counseling/testing completed, at what institution was this done? _____<br>**Please provide a copy of your genetic counseling / testing results to our office.** |

**FAMILY MEDICAL HISTORY**

*Please list your biological family medical history below. If family history unknown, due to adoption, please check* ☐

| Relationship | Alive / Deceased | Health Issues (Diagnosis) | Age when health issue or diagnosis occurred |
|---|---|---|---|
| Biological Mother | | | |
| Biological Father | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Sister(s) | | | |
| Brother(s) | | | |
| Daughter(s) / Son(s) | | | |
| Aunt(s) / Uncle(s) | | | |