WINTER PARK SURGICAL ASSOCIATES
General, Laparoscopic & Robotic Surgery

CHARLES J KOLLER MD FACS
Diplomate, American Board of Surgery

PATIENT MEDICAL HISTORY

Today's Date: _____

Patient's Name: _____ Date of Birth: _____
Last *First* *M*

If patient is a minor, Parents' Name(s): _____

Reason For Today's Visit: _____

How did you hear about us? ☐ Internet/Website ☐ Billboard ☐ Referral by: _____

Do you have any allergies or reactions to medications? ☐ Yes ☐ No (list below)

1. _____ 3. _____
2. _____ 4. _____

List chronic medical conditions, e.g., high blood pressure, diabetes, cholesterol, low thyroid, etc...

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list all surgery you have had and include date (month/year)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list all current medications including prescription and non prescription drugs:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

List Pertinent Family History i.e. Diabetes, Heart Disease, Cancer, etc...

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you had colonoscopy ? ☐ Yes ☐ No Date: _____

Have you had endoscopy (EGD) ? ☐ Yes ☐ No Date: _____

Date of most recent mammogram (if applicable): _____

Are you currently having or have you had *(check all that apply)*:

☐ Fever	☐ Night Sweats	☐ Chills	☐ Swollen Lymph Nodes	☐ Lumps or Bumps
☐ Unexplained Weight Loss	If so, How Much? _____ Lbs.			
☐ Nausea	☐ Vomiting	☐ Abdominal Pain	☐ Food Intolerance	
☐ Change in Bowel Habits	☐ Constipation	☐ Diarrhea	☐ Rectal Pain	
☐ Asthma	☐ COPD	☐ Sleep Apnea	Do You Use Oxygen? ☐ Yes ☐ No	
☐ Chest Pain	☐ Shortness of Breath	☐ Swollen Legs		
☐ Kidney Failure	☐ Kidney Stones	☐ Dialysis	☐ Heart Stents	
☐ Anemia	☐ Clotting Problems	☐ Excessive Bleeding	☐ Low Platelets	
☐ Lupus	☐ Fibromyalgia	☐ Migraine Headaches	☐ Endrometriosis	
☐ Diabetes	☐ Low Blood Sugar	☐ Weakness	☐ Chronic Fatigue	
Hepatitis: ☐ A ☐ B ☐ C		☐ HIV/AIDS	☐ MRSA	

Social History:

Current occupation _____ Retired ☐ Yes ☐ No

Education: ☐ High School ☐ Vocational School ☐ College ☐ Graduate School

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you drink alcohol? ☐ Yes ☐ No If Yes, how many drinks per day/week? _____

Do you smoke cigarettes? ☐ Yes ☐ No If, Yes how many packs per day? _____

Do use smoke marijuana? ☐ Yes ☐ No If Yes, how often? ☐ Daily ☐ Weekly ☐ Monthly

Have you ever: Used intravenous drugs? ☐ Yes ☐ No

Had a Blood Transfusion? ☐ Yes ☐ No

Signature of patient or guardian: _____ Date: _____

Physician Notes: _____