



Montclair Surgical Associates, PA

Medical Information Form

Name _____ Date of Birth _____ Age _____

Reason for seeing the doctor today _____

Please check off any of the following disorders from which you currently suffer or have suffered in the past.

Cardiovascular

- Hypertension
- Angina (chest pain)
- Heart Attack | date(s) _____
- Arrhythmia (irregular heartbeat)
- Bleeding Disorder
- Poor Circulation | Edema
- Phlebitis | Leg ulcers

Pulmonary

- Asthma
- Emphysema
- Bronchitis
- Pneumonia
- Lung Cancer
- Tuberculosis

Urinary Tract

- Urinary Tract Infection
- Kidney Stone
- Acute | Chronic Renal Failure
- Need for Dialysis
- Kidney Tumor
- Enlarged Prostate
- Prostate Cancer
- Sexually Transmitted Disease | HIV

Endocrine (Glands)

- Diabetes Mellitus
- Thyroid Disorders
- Pituitary Disorders
- Adrenal Disorders

Gastrointestinal Tract

- Ulcers
- Hiatal Hernia | GERD
- Stomach Cancer
- Gallbladder Disease
- Colon Polyps | Cancer
- Diverticulosis
- Intestinal Obstruction (blockage)
- Hepatitis | Jaundice

Neurological

- Stroke | TIA
- Seizures | Epilepsy
- Paralysis | Palsy
- Multiple Sclerosis
- Brain Tumor

Social History

- Cigarettes | packs a day ____ x ____ yrs
- Alcohol use ____ drinks per day
- Drug Abuse | type _____

Allergies to food & medications

- Seasonal Allergies

List all current medications

List prior hospitalizations and surgeries

Family History of Illnesses

Mother _____

Father _____

Sisters _____

Brothers _____

Others _____

Breast Disease Risk Assessment

Age at menarche (1st menstrual cycle) _____

of pregnancies _____

of children _____

Age at first full term pregnancy _____

Have you ever used hormones YES | NO

Did you ever breast feed YES | NO

Have you ever had a breast biopsy YES | NO

Age at menopause _____

Family history of breast cancer _____

Family history of cancer _____

Type _____

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