

ADVANCED SURGICAL INSTITUTE

Marco V. Canulla, M.D.

14418 W. Meeker Boulevard, Suite 202 • Sun City West, AZ 85375 • P: 623-584-4882 • F: 623-584-6732

PATIENT HISTORY

Name: _____ Age: _____ Date of Birth: _____ Today's Date: _____

List other doctors treating you: _____

Main complaint: _____ Date of onset: _____

DO YOU HAVE A HISTORY OF:

Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lung Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gout	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach/Ulcer Problem	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arterial Insufficiency	<input type="checkbox"/> No <input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Blood Transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes	Venous Stasis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Colon Polyps	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chemical Dependence	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding Tendency	<input type="checkbox"/> No <input type="checkbox"/> Yes	Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Breast Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Colitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes
Colon Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anesthesia Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other Cancer – Type: _____		Location: _____			

LIST ALL PAST OPERATIONS AND SERIOUS ILLNESSES:

Type of Operation or Illness	Month and Year	City and State

Recent x-rays, labs or tests	Date	Facility/Doctor

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dose	Frequency	For what condition?

Do you have allergies to any medications? No Yes – please list: _____

Do you have any non-medication allergies: No Yes – please list: _____

Do you smoke? No – Date quit: _____ Yes – How much? _____

Do you drink alcohol? No – Date quit: _____ Yes – How much? _____

Previous steroid use? No – Date quit: _____ Yes – How much? _____

FAMILY HISTORY	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<input type="checkbox"/> Brother <input type="checkbox"/> Sister				

HAS ANY BLOOD RELATIVE EVER HAD:

Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____	Lung Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____	Atherosclerosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____
Bleeding Tendency	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____	Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____
Colon Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____	Anesthetic Reaction	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____
Colitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____	Congenital Deformity	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____
Breast Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Relative: _____			