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SURGERY SPECIALISTS

of Saint Louis

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MEDICAL HISTORY FORM

Name _____ Date _____ Date of Birth _____

Reason for Office Visit:

Medical History:

Operations: (include dates)

Medications: (please list)

Do You Take Any of the Following Medications? (check all that apply)

- Coumadin (warfarin) Aspirin daily Plavix (clopidogrel bisulfate)
 Glucophage (metformin)

Allergies: (list symptoms such as rash or trouble breathing)

Family History:

Social History: Smoking (years/packs per day) _____

Alcohol _____ Diet _____ Other _____

Medical Problems: (check all that apply)

- Cardiac:** Heart Attack Irregular Heart Beat Heart Murmur Chest Pain
 Awaken Short of Breath Leaky/Abnormal Valves Sleep with Head Elevated

- Pulmonary:** Coughing Blood or Sputum Emphysema Asthma
 Shortness of Breath with Exercise/Stair Climbing Pneumonia

Gastrointestinal: Difficulty Swallowing Hiatal Hernia Peptic Ulcer
 Pancreatitis Loss of Appetite Gastritis Gallstones Hepatitis
 Diarrhea Constipation Weight Gain Weight Loss Hemorrhoids
 Dark or Bloody Stool Jaundice (yellow skin or eyes)

Hands/Fingers/Arms/Shoulders: Frequent Use of Computer Keyboard/Mouse
 Finger Numbness Stiffness Pain Upon Awakening Injuries/Falls on Hands
 Lumps/Bumps Anywhere Awakened at Night with Numbness/Pain
 Difficulty Doing Daily Activities If yes, list activities_____

Breast History: Masses Cysts Pain Nipple Drainage
 Yearly Mammogram Abnormal Mammogram Cancer

Genitourinary: Painful Urination Frequent Urination Infections
 Cloudy or Bloody Urine Night Time Urination PSA Level Cancer

Endocrine: Diabetes Thyroid Problems

Gynecologic: Irregular Menstrual Periods Possible Pregnancy
 Menopausal Post-Menopausal Bleeding

Hematologic: History of Bleeding Anemia Blood Transfusion

Neurological: Seizure/Convulsions Numbness Weakness Stroke

Other Problems: (please list)

Explanation of above problems:

Who referred you to our office?

Thank You!

Surgery Specialists of St. Louis

Reviewed_____FD