



# Stanly Surgical Weight Loss Center

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## MEDICAL HISTORY

Primary Care  
Physician: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Type of Surgeries: \_\_\_\_\_

Social History: Tobacco Use: \_\_\_\_\_  
Alcohol Use: \_\_\_\_\_

Familial Diseases: (Circle) (Parents, aunts, uncles, brother/sister)

Cancer      Heart Disease      Lung Disease      Diabetes      Tuberculosis      Kidney Disease

### REVIEW OF SYSTEMS DO YOU HAVE ANY OF THE FOLLOWING?

	Yes	No		Yes	No
1. Central Nervous System:			7. Genito-Urinary System:		
Headaches	_____	_____	Blood in Urine	_____	_____
Stroke	_____	_____	Kidney Stones	_____	_____
Seizures	_____	_____	Kidney Infections	_____	_____
Muscle Weakness	_____	_____	Prostate Problems	_____	_____
			Frequency/Pain/Burning	_____	_____
2. Respiratory System:			On Urination	_____	_____
Asthma	_____	_____	8. Endocrine:		
Pneumonia	_____	_____	Diabetes	_____	_____
Emphysema	_____	_____	Thyroid Disease	_____	_____
TB	_____	_____			
Cough/Sputum/Blood	_____	_____	9. Musculo-Skeletal:		
			Varicose Veins	_____	_____
3. Cardiovascular System:			Phlebitis	_____	_____
Heart Murmur	_____	_____	Arthritis	_____	_____
High Blood Pressure	_____	_____	Joint Pain	_____	_____
Heart Attack, Chest Pain	_____	_____			
Congestive Heart Failure	_____	_____	10. Breast:		
Irregular Heartbeat	_____	_____	Pain	_____	_____
Swelling of Feet	_____	_____	Lump	_____	_____
Cramps in Legs	_____	_____	Discharge	_____	_____
4. Hematopoietic System:			11. Ears/Nose/Throat:		
Bleeding Disorder	_____	_____	Dentures	_____	_____
Anemia	_____	_____	Hearing Loss	_____	_____
Blood Transfusion	_____	_____			
Sickle Cell	_____	_____	12. Constitutional:		
			Weight Loss	_____	_____
5. Eyes:			Weight Gain	_____	_____
Contact Lens/Glasses	_____	_____	Fatigue	_____	_____
Cataracts	_____	_____	Night Sweats	_____	_____
Glaucoma	_____	_____			
Vision Changes	_____	_____	13. Psychiatry:		
			Depression	_____	_____
6. Gastrointestinal System:			Anxiety	_____	_____
Hiatal Hernia	_____	_____	Insomnia	_____	_____
Ulcer Disease	_____	_____			
Gallstones	_____	_____	14. Immune / Allergic		
Diarrhea / Constipation	_____	_____	Allergies	_____	_____
Hemorrhoids	_____	_____	Infectious Disease	_____	_____
Blood in Stools	_____	_____			