Upper Valley Professional Corporation
Premier Health Partners

Miami County Surgeons

Name: _____

Referring Doctor: _____ Primary Care Doctor: _____

Allergies/Reactions:

_____

_____

_____

Do you have a **LATEX** Allergy? Yes No

Medications you are currently taking:

Medication	Dose	Frequency

Please circle any of the following ILLNESSES that **YOU** have had:

Heart Attack	Brain Cancer	Blood Clots
Heart Failure	Breast Cancer	Phlebitis
High Blood Pressure	Lung Cancer	Anemia
Stroke	Colon Polyps	Cirrhosis
Asthma or Emphysema	Colon/Rectal Cancer	HIV
Chronic Bronchitis	Gastric Cancer	Kidney Disease
Tuberculosis	Other Cancer (below)	Recurrent UTI
Pneumonia	Severe Arthritis	STD's
Diabetes	Jaundice	Anesthesia Problems
Seizure/Epilepsy	Hepatitis	Bleeding Problems
Psychiatric Problems	Gallbladder Disease	Ulcers
Migraine Headaches	Goiter/Thyroid	Colitis

Other Serious illnesses: _____

_____

(Turn Over)

Please circle any of the following SURGERIES that **YOU** have had. List date & hospital.

Appendix	Prostate	Tubal Ligation
Cataract	Stomach	Varicose Veins
Cesarean Section	Thyroid	Breast Surgery
Colonoscopy	Tonsillectomy	Lung Surgery
EGD	Hernia (location)	Colon Surgery
Gallbladder	Hysterectomy	Hemorrhoid
Removal of Ovaries	Other:	

Please list any significant health issues (illnesses/cancers) with your **IMMEDIATE FAMILY** (mother, father, brother, sister):

_____

_____

_____

If today's consult is for **Breast**, please complete the following:

Age first menstrual period: _____ Did You Breast Feed? Y N

Number of pregnancies: _____ Taken Birth Control? Y N

Number of live births: _____ Last Pap Smear: _____

Age of first pregnancy: _____

Last Mammogram: _____ Location: _____
