Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

General Surgery

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Intake Questionnaire

We wish to ensure that our history and records are as complete and accurate as possible. Before you see the surgeon, please take a few minutes to fill out this intake questionnaire. We greatly appreciate your time.

Patient Name:_____ Date:_____

Allergies to Medication:_____

_____

MEDICATION LIST: Please list any medications that you are currently taking.

Medication	Dosage	Frequency	Indication

PAST MEDICAL HISTORY: Please list your medical diagnosis.

_____

_____

_____

_____

_____

Do you have now or have you ever had any of the following medical problems?

- ❑ Diabetes
- ❑ Anemia
- ❑ Blood Clot or Embolus
- ❑ Abnormal Bleeding or Bruising
- ❑ Prior Blood Transfusion
- ❑ Heart Attack or Angina
- ❑ Irregular Heart rhythm or Palpitations
- ❑ Congestive Heart Failure
- ❑ Rheumatic Fever
- ❑ Heart Murmur
- ❑ Stroke
- ❑ Seizure or epilepsy
- ❑ Peripheral Edema
- ❑ Asthma
- ❑ Emphysema or COPD
- ❑ Sleep Apnea
- ❑ Radiation Exposure
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Cancer:_____
- ❑ Hernia
- ❑ Gallstones or Inflammation of Gallbladder
- ❑ Gastroesophageal Reflux Disease or Frequent heartburn
- ❑ Hiatal Hernia or Paraesophageal Hernia
- ❑ Diverticulitis
- ❑ Diarrhea
- ❑ Constipation
- ❑ Other Bowel Disease:_____

Problems list Cont'd:

- ❑ Liver Problems or Hepatitis
- ❑ Enlarged Spleen
- ❑ Depression
- ❑ Anxiety
- ❑ Psychiatric Illness
- ❑ Alcoholism
- ❑ Substance Abuse
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ High Triglycerides
- ❑ Gout
- ❑ Kidney or Bladder problems
- ❑ Back Pain
- ❑ Arthritis, which joint?_____

For Patients being seen for a breast problem:

Age at Menarche (first period):_____ Do you still have regular periods? ❑ Yes ❑ No

If not, at what age did you go through menopause?_____

How many times have you been pregnant?_____ How many Children?_____

Did you breastfeed one or more of your children? ❑ Yes ❑ No How Long?_____

Are you currently on or have you ever been on oral contraceptive pills? ❑ Yes ❑ No

For how long?_____

Are you currently on or have you ever been on hormone replacement therapy (estrogen or progesterone)? Which one?_____ For how long?_____

Have you ever had a breast biopsy? ❑ Yes ❑ No

What was the pathology report?_____

Has anyone in your family had breast cancer, DCIS, or other breast pathology? ❑ Yes ❑ No

If so, how are they related to you and at what age was it diagnosed?_____

_____

Have you ever had breast cancer, DCIS, or other breast pathology? ❑ Yes ❑ No

If so, at what age and what treatment did you receive?_____

_____

PAST SURGICAL HISTORY: Please list the dates of all prior operations, the reason for the operation, the surgeon, and hospital name.

Operation	Reason	Date	Surgeon/Hospital

Exercise Tolerance:

Can you walk from a distant parking space without stopping to rest?_____

Can you climb one flight of stairs without stopping to rest?_____

Can you climb two flights of stairs without stopping to rest?_____

If you stop to rest, is it because of chest pain, shortness of breath, joint pain, or other issues?

_____

_____

REVIEW OF SYSTEMS: Do you CURRENTLY have any of the following symptoms?

- ❑ Fatigue
- ❑ Weight loss (intentional or unintentional)
- ❑ Fever or chills
- ❑ Yellowing of the skin (Jaundice)
- ❑ Rash
- ❑ Excessive bleeding following minor cuts or dental surgery, easy bruising
- ❑ Problems with vision
- ❑ Yellowing of the sclera (whites of the eyes)
- ❑ Swollen lymph nodes
- ❑ Chest pain or pressure
- ❑ Blackouts or periods of dizziness
- ❑ Palpitations or irregular heartbeats
- ❑ Difficulty breathing or shortness of breath
- ❑ Chronic cough or sputum (phlegm) production
- ❑ Blood in your sputum
- ❑ Difficulty or pain on swallowing
- ❑ Acid taste in your mouth or burning in your chest (heartburn)
- ❑ Abdominal pain
- ❑ Abdominal distension
- ❑ Nausea
- ❑ Vomiting
- ❑ Black or tarry stools
- ❑ Diarrhea
- ❑ Frequent or new constipation
- ❑ Change in caliber of stool (skinny stool)
- ❑ Joint pains
- ❑ Swelling of the legs
- ❑ Episodes of confusion
- ❑ Temporary loss or blurring of vision
- ❑ Temporary weakness of one or more limbs
- ❑ Facial weakness or numbness
- ❑ Burning with urination or frequent urination

FOR WOMEN: ❑ Breast mass? ❑ Nipple discharge? ❑ Changes in skin of the breast? ❑ Pregnancy?

SOCIAL HISTORY:

Occupation:_____

Marital Status: ❑ single ❑ married ❑ domestic partner ❑ widow(er) ❑ divorced

Do you live alone? ❑ Yes ❑ No If so, with whom do you live?_____

Children/Grandchildren? Ages?_____

Do you smoke? ❑ Yes ❑ No If so, how many pack(s)/day & for how long?_____

Have you smoked in the past? ❑Yes ❑No

If so, how many pack(s)/day & for how long?_____

When did you quit?_____

Do you drink alcohol? ❑ Yes ❑ No

If so, how many alcoholic beverages do you drink per week?_____

Do you or have you ever used IV drugs or other street drugs?_____

FAMILY MEDICAL HISTORY: Please list the major medical problems of all first and second degree relatives (including, but not limited to: cancer, heart disease, stroke, diabetes, and any other problems with anesthesia). Please be specific.

Cancers Type		Relative	Age at Diagnosis
Diabetes	Type I or II	Relative	Age at Diagnosis
Stroke or Heart Attack		Relative	Age at Diagnosis
Other medical problems		Relative	Age at Diagnosis
Problems with Anesthesia		Relative	Age at Diagnosis

Rev. 2017-06-06 DF