Kathryn A. Wagner, MD, FACS

PERSONAL INFORMATION

NAME:	**DATE OF BIRTH:**	**AGE:**	**DATE:**
Name of doctor who sent you to our office:			
Name of Primary Care doctor:			
Why are you here today?			

Please list all surgeries and procedures you've had (no matter how long ago) and approximate year (typed list is OK):		**Are you allergic to any medications or foods? Please list all with reaction:**	
Procedures/ Surgeries	**Year**	**Medication/ Food Allergy**	**Reaction**

Are you allergic to latex?	☐ YES ☐ NO
Do you take aspirin daily or several times a week?	☐ 81 mg/ baby aspirin ☐ 325 mg
Do you take coumadin/ warfarin / xarelto?	☐ YES ☐ NO
Do you take herbs, roots, or medicinal tea?	☐ YES ☐ NO List:_____

SOCIAL HISTORY

Marital Status (check box)	☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOW
Occupation:	**Company:**
Do you drink alcohol?	☐ YES ☐ NO **How many drinks per day?**
Do you smoke?	☐ YES ☐ NO **How many packs/ cigarette per day?**
Do you take any of the following:	☐ Nicotine gum(mg/day:_____) ☐ Nicotine patch(mg/day:_____) ☐ Vape(mg/day:_____)
Do you take any recreational drugs?	☐ YES ☐ NO
If yes, please list all below. This is very important for anesthesia for surgery.	

FEMALE HISTORY

Age of first menstrual cycle:			
Number of pregnancies:	**How many babies have you had:**	**Age you first gave birth:**	
Any miscarriages or abortions? ☐ YES ☐ NO	**No. of Miscarriage:**	**No. of Abortion:**	
Did you nurse/ breast feed? ☐ YES ☐ NO	**How long:**		
Are you still having regular periods? ☐ YES ☐ NO	**Age at menopause:**		
Have you ever taken oral contraceptives? ☐ YES ☐ NO	**No. of years:**	**Current user** ☐ YES ☐ NO	
Have you ever taken hormone replacement? ☐ YES ☐ NO	**No. of years:**	**Current user** ☐ YES ☐ NO	
If you've had a hysterectomy, number of ovaries you still have: ☐ ONE ☐ TWO ☐ NONE			

Please check if you have any of the following conditions:

Lump in breast ☐	**Shortness of breath** ☐	**Headaches** ☐
Change in breast skin ☐	**Cough** ☐	**Fever/ Chills** ☐
Breast pain ☐	**Body pains (not joints)** ☐	**Confusion** ☐
Nipple discharge ☐	**Abdominal pain** ☐	**Weight loss or gain** ☐
Pain in underarm ☐	**Lack of appetite** ☐	**Anxiety** ☐
Heaviness or swelling of arm ☐	**Nausea/ vomiting** ☐	**Tingling/ Numbness** ☐

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NAME:		DATE OF BIRTH:			AGE:	DATE:
REVIEW OF SYSTEMS						
SYSTEM	***(check all that apply)***	✓	**MEDICATIONS**	**DOSE**	**No. of times/day**	**OTHER MEDICAL CONDITION**
NEURO	Convulsions/ Seizures					
	Migraines/ Headaches					
	Strokes/ TIAs					
	Paralysis/ Weakness					**SPECIALIST:**
HEART	Chest pain/ Angina					
	Heart Valve abnormality					
	High Blood Pressure					
	Congestive Heart Failure					
	Heart Attack/ MI					
	Irregular Heart Beat					**SPECIALIST:**
LUNGS	Sleep apnea/ Snoring/ CPAP					
	Asthma/ Emphysema					
	Shortness of breath/ Chronic cough					**SPECIALIST:**
KIDNEYS	Blood in Urine					
	Frequent bladder infection					
	Kidney infections/ Kidney failures					**SPECIALIST:**
ABDOMEN	Blood in stools/ Black stools					
	Chronic Diarrhea or Constipation					
	Nausea or Vomiting					
	Pain or difficulty in swallowing					
	Chronic heartburn/ Acid Reflux					
	Hepatitis A,B,C, or D					
	Stomach ulcers					
	Pancreatitis					
	Gallstones					**SPECIALIST:**
ENDOCRINE (Hormones)	Thyroid Disease					
	Diabetes					
	Early Menopause					**SPECIALIST:**
BLOOD/ SYSTEM	Anemia					
	Easy Bruising					
	Blood clots in deep veins or lungs					
	Blood transfusion					
	HIV/ AIDS					**SPECIALIST:**
VISION	Blindness/ Cataracts/ Glaucoma/ Macular Degeneration					
	Eyeglasses/ Contact lenses					**SPECIALIST:**
HEARING	Deafness/ Hearing Aids					
	Vertigo/ Chronic ringing					**SPECIALIST:**
MOUTH	Removable dentures/ dental appliances					
	Chronic gum infections/ teeth problems					**SPECIALIST:**
SKIN	Chronic rashes or conditions					
	Unusual moles					**SPECIALIST:**
MUSCULO-SKELETAL	Fibromyalgia					
	Arthritis					
	Joint replacements					
	Carpal Tunnel Syndrome					**SPECIALIST:**
PSYCH	Depression/ Anxiety Disorder					
	Schizophrenia/ Hallucinations					
	Suicidal Attempts					
	Anorexia/ Bulimia					**SPECIALIST:**