WinterPark
HERNIA CENTER

Charles J. Koller, M.D., P.A.

PATIENT MEDICAL HISTORY

Today's Date: ______________

Patient's Legal Name: ____ Date of Birth: ______________
Last First M

If Minor, Parents' Names: ____

Reason For Visit: ____

How did you hear about us? Internet/Website Billboard Referral by: ______________________

Do you have any allergies or reactions to medications? Yes No (list below)

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

List chronic medical conditions, e.g., high blood pressure, diabetes, cholesterol, low thyroid, etc...

1. ______________________ 5. ______________________

2. ______________________ 6. ______________________

3. ______________________ 7. ______________________

4. ______________________ 8. ______________________

Please list all surgery you have had and include date (month/year)

1. ______________________ 5. ______________________

2. ______________________ 6. ______________________

3. ______________________ 7. ______________________

4. ______________________ 8. ______________________

Please list all current medications including prescription and non prescription drugs, e.g., aspirin:

1. ______________________ 6. ______________________

2. ______________________ 7. ______________________

3. ______________________ 8. ______________________

4. ______________________ 9. ______________________

5. ______________________ 10. ______________________

Have you had colonoscopy ? Yes No Date: ______________

Have you had endoscopy (EGD) ? Yes No Date ______________

Date of most recent mammogram (if applicable) ______________

Are you currently having or have you had *(check all that apply)*:

Fever	Night Sweats	Chills	Swollen Lymph Nodes
Weight Loss	If so, How Much? ________	Lbs.	
Nausea	Vomiting	Abdominal Pain	Food Intolerance
Vomiting Blood	Rectal Bleeding	Blood In Urine	
Asthma	COPD	Sleep Apnea	Do You Use Oxygen? Yes No
Chest Pain	Shortness of Breath	Swollen Legs	
Kidney Failure	Kidney Stones	Dialysis	Heart Stents
Anemia	Clotting Problems	Excessive Bleeding	Low Platelets
Lupus	Fibromyalgia	Migraine Headaches	Endrometriosis
Diabetes	Low Blood Sugar	Weakness	Chronic Fatigue
Hepatitis: A B C		HIV/AIDS	MRSA

Social History:

Current occupation ______________________ Retired Yes No

Education: High School College Graduate School

Marital status: Single Married Divorced Widowed

Do you drink alcohol? Yes No If Yes, how many drinks per week? __________

Do you smoke cigarettes? Yes No If, Yes how many packs per day? __________

Do use smoke marijuana? Yes No If Yes, how often? Daily Weekly Monthly

Have you ever: Used intravenous drugs? Yes No

Had a Blood Transfusion? Yes No

Signature of patient or guardian: ______________________ Date: __________

Physician Notes: ______________________