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?
☐ Chest Pain	☐ Shortness of Breath	☐ Swollen Legs	○ Yes ○ No
☐ 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 you 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: _____