WK BOSSIER SURGICAL ASSOCIATES
MEDICAL INFORMATION

Date_____

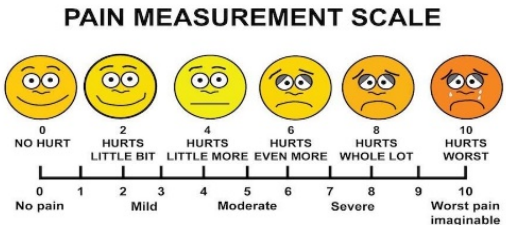
Name_____**DOB**_____**Age**____**Weight**_____**Height**_____
Vitals_____
Reason for visit:_____
Primary Care MD_____ **Referring MD**_____

Past Medical History: ____ None

____Arthritis	____GERD	____Mitral Valve Prolapse
____Asthma	____Glaucoma	____Multiple Sclerosis
____Atrial Fibrillation	____Gout	
	____Hearing loss	____Palpitations
____Atrial Flutter	____Heart Valve Replaced	____Pneumonia
____Autoimmune Disease	____Heart Murmur	____Polio
____Blood Disorder	____Hemorrhoids	____Prostate Problems
____Breast Cancer	____Hepatitis	____Peptic Ulcer Disease
____Bronchitis	____Hiatal Hernia	____Renal Disorders
____Coronary Artery Disease	____HIV	____Shortness of Breath
____Colon Cancer	____High Cholesterol	____Skin Disorders
____Constipation	____High Blood Pressure	____Sleep Apnea
____COPD	____IBS	____Stroke/TIA
____Crohn's Disease	____Kidney Cancer	____Taking Blood thinner
____Diabetes Mellitus	____Liver Disease	____Thyroid Disorder
____Emphysema	____Lung Cancer	____Tuberculosis
____Epilepsy	____Heart Attack	____Ulcerative Colitis
____Fibromyalgia	____Migraines/headache	____Upper GI Bleed
____Other_____		____Vision loss

Allergies:_____

Pain at present time



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Date_____

Name_____**DOB**_____

Social History:

____Alcohol Use: Amount/ Frequency_____
____Previous Alcohol Use
____Tobacco Use: Type / Amount_____
____Previous Smoker
____Caffeine Use: _____
____Drug Use: __Recreational_____ Prescription_____
____Do you feel safe in your environment?
____Have you fallen in the past 6 months?

Family History

____Breast Cancer
____Coronary Artery Disease
____Colon Cancer
____COPD
____Diabetes Mellitus
____Gastric Cancer
____Heart Disease
____High Blood Pressure
____Other:_____

____Leukemia
____Lung Cancer
____Lymphoma
____Pancreatic Cancer
____Peripheral Vascular Disease
____Kidney Cancer
____Other cancer_____

Recent Work Up

____Cardiac Evaluation: Date_____ Cardiologist:_____
____Mammogram: Date_____
____Colonoscopy(Scope of Colon): Date:_____
____Other:_____Date:_____
*Have you received an influenza vaccine "flu shot" this year?__ Date_____
*Have you received the COVID 19 vaccine?__ Date_____

WK **BOSSIER SURGICAL ASSOCIATES**
SURGICAL HISTORY

Date_____
Name_____**DOB**_____

Past Surgical History:

___AAA Repair
___Appendectomy
___Gallbladder Removal
___Colectomy
___Femoral Hernia Repair
___Hemorrhoidectomy
____Hernia Repair
____Incisional Hernia Repair
____Inguinal Hernia Repair
___Right ___Left
____Pancreatectomy
____Abdominal Wall Repair
____Small Bowel Resection
____Splenectomy
____Surgery for Ulcer
____Umbilical Hernia Repair
____Ventral Hernia Repair
____Other_____

Respiratory Surgery:

___Lung Surgery
___Tonsils/ Adenoids

Thyroid:

___Radiation of Thyroid
___Thyroid Surgery

Cardiac Surgery:

____Heart Valve Replacement
____Cath/ Stents
____Pacemaker
____Defibrillator
____CABG: _____
____Carotid Endarterectomy

Female:

___Breast Surgery: _____
___Hysterectomy
___Tubal Ligation
___Cesarean Section

Male:

____Prostate Surgery

GU:

____Kidney Removal ____Lithotripsy
____Rt ___Lt

GI:

___Upper EGD
___Ileostomy/Colostomy
____Sigmoidoscopy
____Bariatric Bypass/Banding

Musculoskeletal:

___Back Surgery
___Rotator Cuff Repair
___Right___Left
____Hip Replacement
___Right___Left
____Knee Replacement
___Right___Left

Other:

____Temporal Artery Biopsy
___Cataract Surgery ____Craniotomy
____Other:_____

PATIENT SIGNATURE_____ DATE_____

REVIEWED BY_____ DATE/TIME_____