

**Banner Good Samaritan  
Medical Center**

**PRE-SURGICAL ASSESSMENT PROGRAM  
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Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Preferred Pharmacy and FAX # \_\_\_\_\_

Referring Physician Name \_\_\_\_\_ Other Doctors involved in your care: \_\_\_\_\_

Reason for Today's visit: \_\_\_\_\_

Date of Injury or Onset of problem \_\_\_\_\_ Work Related  No  Yes → Worker's Comp Claim Filed?  No  Yes

Is this related to an accident?  No  Yes →  Auto  Other \_\_\_\_\_

Is there legal action pending regarding this?  No  Yes → Attorney Name & Number \_\_\_\_\_

**ALLERGIES: Are you allergic to any drugs?**  No  Yes → list all DRUG ALLERGIES including adverse reaction

Are you allergic to?	DRUG	REACTION
Eggs <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Iodine <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Latex <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Nuts <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Penicillin <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Sulfa <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Tape <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____

**CURRENT MEDICATIONS: Do you take any medication?**  No  Yes → List all including Over the counter, herbs, vitamins

Name	Dose and frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a cortisone injection:  No  Yes → Area injected and response to injection: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**MEDICAL HISTORY:**

- Allergies (Hay Fever)     Cancer     Hepatitis/Jaundice     Migraine Headaches     Sleep Apnea
- Anemia     Depression     High Blood Pressure     Multiple Sclerosis     Stomach/Ulcers
- Arthritis     Diabetes     High Cholesterol     Neurological Problems     Stroke
- Asthma     Emphysema     HIV/AIDS     Old Fracture     Thyroid Disease
- Birth Defect     Epilepsy/Seizures     Kidneys     Osteomyelitis     Tuberculosis
- Bladder     Fibromyalgia     Liver     Osteoporosis     Wound Healing
- Bleeding Disorder     Gout     Lungs     Polio     Other
- Blood Clots     Heart Disease     Mental Illness     Sickle Cell

**Give Details to "Other" and any positive responses:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SURGICAL HISTORY: Have you undergone any surgical procedures?  No  Yes → List all surgeries, include right or left when indicated**

Year	Surgery	Year	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ANESTHESIA: Have you ever had any problems with anesthesia  No  Yes → Explain**

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY:**

- Marital Status     Single     Married     Widowed     Divorced     Separated
- Current Residence     Home     Apt/Condo     Assisted Living     Nursing Home     Other

Occupation: (or occupation prior to retirement) \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Year You Arrived in Arizona: \_\_\_\_\_

Do you smoke or chew tobacco? (circle one)     Yes     No  
If you smoked in the past, when did you quit? \_\_\_\_\_

Do you drink alcohol?     Yes     No  
If you do drink alcohol, How Much per day \_\_\_\_\_

Do you drink caffeinated beverages? (circle one)     Yes     No  
If so, how many beverages per day? \_\_\_\_\_

Do you use any illegal substances/drugs? (circle one)     Yes     No  
If you do use drugs, what type/how often? \_\_\_\_\_

Do you wear Seat Belts at ALL times?     Yes     No  
How Many Times A Week Do You Exercise?     0     1     2     3     4+

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**FAMILY HISTORY:**

(indicate major medical problems, whether alive or deceased and cause of death, if known)

	Child	Mother	Father	Siblings		Child	Mother	Father	Siblings
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DVT (Blood Clots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Give Details to "Other" and any positive responses: \_\_\_\_\_

INDICATE DATE OF YOUR LAST:	DATE	DATE
Tetanus/Td Vaccine	_____	Colonoscopy _____
Flu Vaccine	_____	Rectal/Stool for Blood _____
Pneumonia Vaccine	_____	PSA _____
EKG	_____	Mammogram (♀) _____
CXR	_____	Pap Smear (♀) _____
Routine Blood Work	_____	Bone Density/DEXA _____
Stress Test	_____	

**REVIEW OF SYSTEMS:**

<p><b>GENERAL</b></p> <input type="checkbox"/> Unexpected Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>HEART</b></p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmurs <input type="checkbox"/> Fainting <input type="checkbox"/> Palpitations <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>URINARY</b></p> <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Bleeding <input type="checkbox"/> Difficult/Painful Urination <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>MUSCLE/JOINTS</b></p> <input type="checkbox"/> Joint Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Instability <input type="checkbox"/> Redness <input type="checkbox"/> Heat <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all
<p><b>EYES</b></p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Corrective Lens <input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye Redness <input type="checkbox"/> Watery <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>LUNGS</b></p> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Snoring <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>ENDOCRINE</b></p> <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> Excessive Urination <input type="checkbox"/> High Blood Sugar <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>NEUROLOGIC</b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremors <input type="checkbox"/> Unsteady Gait <input type="checkbox"/> Seizure <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all
<p><b>EAR/NOSE/THROAT</b></p> <input type="checkbox"/> Headache <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Earache <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>STOMACH/COLON</b></p> <input type="checkbox"/> Heart Burn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody/Tarry Stools <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>BLOOD</b></p> <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> Blood Clots <input type="checkbox"/> Anemia/Low Blood Counts <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all	<p><b>SKIN</b></p> <input type="checkbox"/> Redness <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Poor Healing <input type="checkbox"/> Skin Changes <input type="checkbox"/> Other _____ <input type="checkbox"/> Check box if NO to all

