Sugery Clinic of Wellington
Sumner Regional Medical Center
1323 North A Street
Wellington, KS 67152-4350
HISTORY AND PHYSICAL

Patient Name:_____ Date of Birth:_____ Age:_____
Primary Physician:_____
Pharmacy:_____

PATIENT DEMOGRAPHICS AND CHIEF COMPLAINT

Today's Date:_____
Person Filling Out Form:_____
Relationship to Patient:_____
Why are you seeing the doctor today?_____
_____

PAST MEDICAL HISTORY

Do you see a doctor regularly for medical reasons? Yes_____ No_____
If yes, for what reason?_____
Have you had any diseases or health problems in the past year? Yes_____ No_____
If yes, please check any of the following that you have had:

_____Cancer	_____ Heart Disease	_____ Stroke	_____ Colitis
_____ Ulcers	_____ Epilepsy	_____ Leukemia	_____ Hepatitis
_____ HIV	_____ AIDS	_____ Headaches	_____ Anemia
_____ MRSA	_____ High Blood Pressure		

Have you had any serious injuries? Yes_____ No_____
If yes, please list the date and type of injury_____
Have you had any surgery in the past? Yes_____ No_____
If yes, please list the **date** and **type** of surgery:
1._____ 2._____
3._____ 4._____
5._____ 6._____
Do you take St. John's Wort? Yes_____ No_____
Do you take any prescribed medicine, over the counter, non-prescribed or health supplements?
Yes_____ No_____
List the name of medication or supplement and how much you take:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Are you allergic to any medications, prescribed or over the counter? Yes_____ No_____
If yes, please list the medication and the reaction you had. (Include aspirin, Tylenol, over the counter medications and herbal remedies)

_____
_____

Are you allergic to any foods? Yes_____ No_____
If yes, please list the food and the reaction_____
_____

Family History

Are there any diseases or illnesses that family members have had? Please check the boxes below for any family member who had had the problem. Under siblings, please write in brother or sister. Under grandmother and grandfather, please write mother or father's side.

	MOTHER	FATHER	SIBLINGS	GRANDMOTHER	GRANDFATHER
Anesthetic Problems					
Breast Cancer					
Colon Cancer					
Cancer (other)					
Diabetes					
Heart Disease					
High Blood Pressure					
Mental Illness					
Stroke					

Other Conditions (please specify)_____
_____
_____
_____
_____