New Patient History

Dr. Kovacev
Advanced Surgical Care

Name : _____ Birthday: _____ Age _____

Ethnicity: _____ Primary Language: _____

Person Completing List: Self: ☐ Other: ☐ If Other Please Print Name: _____

Please Explain the Reason for Your Visit:

_____

Medical History: Place Check Mark in box ☑

High Blood Pressure		Cancer		Depression / Anxiety / Bipolar		Gynecologic Disease	
Diabetes		COPD / Asthma		Visual Problems		Skin Disorders	
CHF		Circulatory Issues		Neuropathy		Hernias	
Stroke		GERD / Reflux		Clotting Disorder		Sexual Dysfunction	
Heart Attack		Ulcers		Cirrhosis		Incontinence	
Seizures		Indigestion		HIV / AIDS		Hemorrhoids	
High Cholesterol		Hepatitis		Autoimmune Disease		Breast Disease	
Arrhythmia		Kidney Disease		Prostate Issues		Other : Write Below	

If not listed above please explain:

_____

Surgical History: Place Check Mark in box ☑

Cardiac		Fatty Tumors		Umbilical Hernia		Amputation	
Chest		Abscess		Groin Hernia		Colonoscopy	
Lung		Reflux		Other Hernia		Upper Endoscopy	
Skin		Rectum		Eye Surgery		Prostate	
Colon		Hysterectomy		Spinal Surgery		Pacemaker / Defribrillator	
Liver		Hemorrhoids		Brain Surgery		Heart Stents	
Gallbladder		C-Section		AV Fistula / Graft		Transplant	
Appendix		Tubal Ligation		Breast Surgery or Biopsy		Catheters / Ports	

If not listed above please explain:

_____

New Patient History

Dr. Kovacev
Advanced Surgical Care

Name: _____ Birthday:_____

Screening History:

Test:		***Year***		***Findings***		***Doctor***	
Colonoscopy							
Breast Cancer							
Gynecologic Cancer							
Prostate Cancer							
Skin Cancer							

Pharmacy: (Name, Location, Phone)

_____

Allergies: (Drug or Food)

_____

_____

Medication List: (Include Vitamins, Daily Aspirin, ect.)

Name of Medicine	***Dose***	***How Often***	***How Long***	***Last Time Taken***

Family History: Place Check Mark in box ☑

Colon Cancer		Liver Disease		Prostate Cancer		Polyps	
Rectal Cancer		Lung Cancer		Crohns Disease		Stomach Cancer	
Heart Disease		Gallbladder Disease		Ulcerative Colitis		Psychiatric Disorder	
Bleeding Disorders		Appendectomy		Breast Cancer		Substance Abuse	
Skin Cancer		Hernias		Uterine / Ovarian Cancer		Other: Write Below	

New Patient History

Dr. Kovacev
Advanced Surgical Care

Name: _____ Birthday: _____

Social History:

Marital Status: (Circle) Married Divorced Widowed Cohabitate Single

Number of Children: _____ Highest Education Completed: _____

Employer: _____ Years at current job: _____

Tobacco Use: (Circle) Never Current: How many years smoking: _____

How Much Do You Smoke and How Often: _____

Do You Use Recreational Drugs (Marijuana, Prescription, etc):_____

Have you EVER Used Recreational Drugs: YES ☐ NO ☐ If yes, when last? _____

Alcohol Use: (how much and how often): _____

Do You Exercise (how much and how often): _____

Have You Had Any Known Exposure to Chemicals / Radiation or Other Environmental Factors of Concern? (asbestos, benzene, chemicals at work, ect.). If so please explain below:

_____

Have You Had Any Recent or Past Viral Infections? YES ☐ NO ☐

Have You Had Any Sexually Transmitted Diseases? YES ☐ NO ☐

Do You Get Regularly Immunized (flu, etc.)? YES ☐ NO ☐

Have you used Vapor or Electronic Cigarettes? YES ☐ NO ☐

Have You Abused Any Other Substances (bath salts, Freon, ect.) YES ☐ NO ☐

Are You on Any Form of Disability or Public Assistance? YES ☐ NO ☐

Have You Been Hospitalized in the Past 1 Year? YES ☐ NO ☐

Who is your Primary Care Doctor? (write below)

_____

Name Address / City Phone

Is there anything you feel is important for Dr. Kovacev to know about you that is not listed?

_____