

Patient Information Form – Dr. Brian Ju
Surgical Professionals – General Surgery
 4135 S. Power Road, Ste 117, Mesa AZ 85212 -- 21321 E. Ocotillo Rd, Ste 102, Queen Creek, AZ 85142

Name: _____ Age: _____ Today's Date: ____ / ____ / ____

Primary Care Doctor: _____ Doctor's Phone: _____

How did you hear about our office? _____

Pharmacy: _____ Cross Streets: _____

What is your main surgical problem: _____

What other medical problems do you have (such as hypertension, diabetes, heart conditions, etc)?

What ALLERGIES to medications do you have? _____

Are you allergic to shellfish? Y / N Are you allergic to IV dye? Y / N

What other surgeries have you had? _____

Have you ever had problems with anesthesia? _____

What medical problems run in your family? _____

Do you smoke? Y / N If so, how many packs a day? _____ **Do you use an electronic cigarette?** Y / N

How many years? _____ If not, have you smoked in the past year? Y / N

Do you drink alcohol? Y / N How many drinks a day? _____ Any history of drug abuse? Y / N

What is your current occupation? _____

Have you RECENTLY had significant problems with any of the following? (Circle if yes)

- | | | | | |
|------------------|--------------------|----------------------|---------------------|------------|
| Severe Headaches | Dizziness | Cough / Congestion | Shortness of Breath | Rash |
| Chest Pain | Nausea or Vomiting | Diarrhea | Blood in Stool | Numbness |
| Loss of Vision | Blacking Out | Burning on Urination | Blood in Urine | Joint Pain |
| Easy Bruising | Palpitations | Fever / Chills | Weight Gain / Loss | |

List your medications below: Be sure to include herbal, contraceptives, and over the counter medications as well

Are you currently or have you recently taken:

- | | |
|-----------------------|-------|
| Aspirin | Y / N |
| Prednisone / Steroids | Y / N |
| Blood Thinners | Y / N |
| Plavix / Lovenox | Y / N |

Have you had:

- | | |
|---------------------------------|-------|
| Blood Work in the Past 30 Days? | Y / N |
| EKG | Y / N |
| Stress Test / Heart Cath | Y / N |

OFFICE USE ONLY	VITALS	PER: _____	OFFICE USE ONLY
BP: _____ / _____	Pulse: _____	Temp: _____	Height: _____ Weight: _____