PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

NAME: ______________________________ TODAY'S DATE: ______________

AGE: _____________ DATE OF BIRTH: ____________________SEX: _______

CHIEF COMPLAINT

SYMPTOM

____

LOCATION

____

DURATION

____

REVIEW OF SYSTEMS CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY

GENERAL	SKIN	HEAD/NECK	BREASTS
CHILLS	BRUISE EASILY	BLEEDING GUMS	DISCHARGE
WEAKNESS	ITCHING	BLURRED VISION	LUMP/MASS
FATIGUE	CHANGE IN MOLES	DIFFICULTY SWALLOWING	PAIN
WEIGHT LOSS	RASH	DOUBLE VISION	BLEEDING
FAINTING	SORES	HOARSENESS	NIPPLE CHANGE
NIGHT SWEATS	SCARS	NOSEBLEEDS	SKIN CHANGE
SWOLLEN NODES	DRYNESS	PERSISTENT COUGH	BLOATEDNESS
ANEMIA		LUMP/MASS	
		PAIN	

LUNGS	HEART	GASTROINTESTINAL	
COUGH	MURMUR	PAIN	GAS
BLOOD	PALPITATIONS	NAUSEA	BELCHING
SHORT OF BREATH	CHEST PAIN/PRESSURE	VOMITING	HEARTBURN
WHEEZING	IRREGULAR HEARTBEAT	POOR APPETITE	HEMORRHOIDS
PAIN	HIGH BLOOD PRESSURE	BLOATING	HERNIAS
CONGESTION	LOW BLOOD PRESSURE	IRREGULAR BOWEL HABITS	INDIGESTION
INHALANT EXPOSURE		CONSTIPATION	RECTAL BLEEDING
PHLEGM		DIARRHEA	FOOD INTOLERANCE

GENITOURINARY		VASCULAR	
URGENCY	DISCHARGE	VARICOSE VEINS	HEAVINESS/TIRED LEGS
INCONTINENCE	SORES	SWELLING/EDEMA	LIMB HAIR LOSS
STRAINING	ERECTION DIFFICULTIES	ACHES	TROPHIC NAILS
STONES	LUMP/MASS	ITCHING	PARASTHESIA
BURNING	SMALL STREAM	CHANGE IN COLOR	BURNING SENSATION
BLOODY URINE		DERMATITIS/ECZEMA	LEG PAIN WHILE WALKING
		ULCERATION	LEG PAIN AT REST
		SUPERFICIAL PHLEBITIS	CRAMPS
		DEEP THROMBOPHLEBITIS	

NEUROLOGICAL		PSYCHIATRIC	
SEIZURES	WEAK GRIP	DEPRESSION	TIMID
VERTIGO	PARALYSIS	IRRITABLE	SUICIDAL THOUGHTS
TREMBLING	DIFFICULTY OF SPEECH	ANXIOUSNESS	EXTREME WORRY
INCOORDINATION	TINGLING/NUMBNESS	HALLUCINATIONS	SEXUAL PROBLEMS
DIZZINESS	LOSS OF MEMORY	INSECURITY	TROUBLED SLEEP

NAME: ____________________________ DOB: ___________ DATE: ________

GYNECOLOGICAL		
SPOTTING	CONTRACEPTION/TYPE	MENSTRUAL FLOW
MENSTRUAL CRAMPS	AGE AT FIRST PERIOD	HEAVY MODERATE LIGHT
DISCHARGE	AGE AT MENOPAUSE	
ITCHING	DURATION OF CYCLE	LAST PERIOD _____/_____/_____
PAINFUL INTERCOURSE	DURATION OF FLOW	
IRREGULAR PERIODS	# OF PREGNANCIES	LAST PAP SMEAR _____/_____/_____
HOT FLASHES	# OF BIRTHS	
PAIN BETWEEN PERIODS	# OF MISCARRIAGES	LAST MAMMOGRAM _____/_____/_____
	# OF ABORTIONS	

PAST MEDICAL HISTORY CHECK ONLY THE ONES YOU HAVE HAD IN THE PAST

PAST GENERAL HEALTH: EXCELLENT GOOD FAIR POOR				
HAY FEVER	SINUSITIS	ANGINA/CHEST PAIN	COLITIS	ARTHRITIS
MUMPS	THYROID PROBLEMS	HEART MURMUR	CROHN'S DISEASE	GOUT
MEASLES	BREAST TROUBLE	HEART PROBLEMS	POLYPS	MIGRANES
RHEUMATIC FEVER	ASTHMA	HIGH CHOLESTEROL	KIDNEY INFECTION	EPILEPSY/SEIZURES
ALLERGIES	BRONCHITIS	STROKE	KIDNEY STONES	PARALYSIS
ANEMIA	PLEURISY	ULCERS	BLADDER PROBLEMS	POLIO
CANCER	PNEUMONIA	JAUNDICE	DIABETES	MENTAL ILLNESS
TUMOR	TUBERCULOSIS	GALLSTONES	SYPHILIS	ALCOHOLISM
BLOOD DISEASE	EMPHYSEMA	PANCREATITIS	GONORRHEA	DEPRESSION
LEUKEMIA	PULMONARY EMBOLISM	LIVER PROBLEMS	HIV/AIDS	NERVOUS BREAKDOWN
SKIN PROBLEMS	PHLEBITIS/THROMBOPHLEBITIS	HEPATITIS	SEXUAL PROBLEMS	OTHERS
CATARACTS	VARICOSE VEINS	PARASITES	PROSTATE PROBLEMS	
TONSILITIS	HYPERTENSION	DYSENTERY	HEMORRHOIDS	

PAST SURGICAL HISTORY			
ABDOMINAL ANEURYSM	CARDIAC STENTS	HEART VALVE REPLACEMENT	NECK SURGERY
ABDOMINAL HERNIA	CATARACT SURGERY	HEMOFFHOIDECTOMY	OVARIAN SURGERY
ADRENALECTOMY	CHOLECYSTECTOMY	HIP REPLACEMENT	PACEMAKER/DEFIBRILLATOR
ANAL FISSURE/ULCER	COLECTOMY	HYSTERECTOMY	PROSTATE SURGERY
APPENDECTOMY	CORONARY ARTERY BYPASS	INGUINAL HERNIA	RECTAL ABSCESS
ARTERIAL BYPASS-LEG	DIALYSIS ACCESS	KNEE SURGERY	THYROIDECTOMY
ARTERIAL STENTS-LEG	DILATION & CURETTAGE (D&C)	LITHOTRIPSY	TONSILLECTOMY
BACK SURGERY	BOWEL SURGERY	LUNG RESECTION	TUBAL LIGATION
CARDIAC CATHERIZATION	GASTRIC SURGERY	MASTECTOMY	UMBILICAL HERNIA

HOSPITALIZATIONS	DATE	HOSPITAL

IMMUNIZATIONS/VACCINATIONS		BLOOD TYPE	BLOOD TRANSFUSIONS
DPT	MEASLES	A+ A-	# OF TRANSFUSIONS
MUMPS	PNEUMOCOCCAL	B+ B-	DATE(S)
SMALLPOX	INFLUENZA	AB+ AB-	___/____/____
TYPHOID	POLIO	O+ O-	___/____/____
TETANUS	MMR		___/____/____

NAME: ______________________________ DOB: ___________ DATE: ________

FAMILY HISTORY

LIST ANY OF THE DISEASES IN THE SECTION ABOVE WHICH RUN IN THE FAMILY

BLOOD RELATIVES ONLY	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	STATE OF HEALTH	ILLNESSES
FATHER					
MOTHER					
BROTHER(S)					
SISTER(S)					
MATERNAL GRANDFATHER					
MATERNAL GRANDMOTHER					
PATERNAL GRANDFATHER					
PATERNAL GRANDMOTHER					

SOCIAL HISTORY

CHECK THE BOXES AND FILL IN

WEIGHT	MENTAL WORK	PHYSICAL WORK	EXERCISE	EDUCATION LEVEL
CURRENT	HEAVY	HEAVY	HEAVY	HIGH SCHOOL
USUAL	MODERATE	MODERATE	MODERATE	VOCATIONAL
MAXIMUM	LIGHT	LIGHT	LIGHT	COLLEGE
MINIMUM	# HOURS / DAY	# HOURS / DAY	# HOURS / WEEK	MASTERS/DOCTORATE

SMOKING	ALCOHOL	CAFFEINE (COFFEE,TEA,COLA)	NUTRITION # OF PORTIONS/WEEK	
NEVER	BEER AMOUNT/WEEK	CUPS PER DAY	MILK	CHICKEN
FORMER	LIQUOR AMOUNT/WEEK	# OF YEARS	MILK PRODUCTS	CEREAL
CURRENT	WINE AMOUNT/WEEK		EGGS	FISH
# PACKS/DAY	SEXUAL ACTIVITY	RECREATIONAL DRUGS	VEGETABLES	SWEETS
# OF YEARS	ACTIVE	# PER DAY	FRUITS	BEEF
	INACTIVE	# OF YEARS	BREADS	PORK

MEDICATIONS

LIST ALL CURRENT PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

NAME	DOSE	HOW OFTEN DO YOU TAKE?	REASON FOR MEDICATION?

ALLERGIES

LIST ALL ALLERGIES AND REACTIONS TO ANY MEDICATIONS

MEDICATION	REACTION
DO YOU HAVE A LATEX ALLERGY? ☐ YES ☐ NO	