Abstraction Encounter Form

SUFFOLK SURGICAL ASSOCIATES, PC

DATE: **PATIENT NAME:** **DOB:**

Vitals: (last visit)
Date _____BP _____Pulse____Resp.____Temp ____Sp02_____Weight _____Height _____

Allergies: (include: Type/Reaction)

Medications: Name Dose Route How often or times per day:
(If sig is unknown look on Database instead of preference list)

Medical History: **** list date of onset next to condition ****

☐ Allergies	☐ Depression	☐ Myocardial infarction
☐ Anemia	☐ Diabetes mellitus	☐ Nerve/muscle disease
☐ Anxiety	☐ Emphysema	☐ Osteoporosis
☐ Arthritis	☐ GERD	☐ Seizures
☐ Asthma	☐ Glaucoma	☐ Sickle cell anemia
☐ Blood transfusion	☐ Heart murmur	☐ Stroke
☐ Cancer	☐ HIV/AIDS	☐ Substance abuse
☐ Cataracts	☐ Hypertension	☐ Thyroid disease
☐ CHF	☐ Kidney disease	☐ Tuberculosis
☐ Clotting disorder	☐ Meningitis	☐ Ulcers
☐ COPD	☐ Rheumatic Fever	☐ STD
☐ Pancreatitis	☐ A-Fib	☐ hemorrhoids
☐ Coronary artery disease	☐ Hyperlipidemia	

Additional Medical History:

DATE: **PATIENT NAME:** **DOB:**

Surgical History: **** list date next to surgery****

□	Appendectomy	□	AICD	□	C-Section
□	Prostate surgery	□	Brain Surgery	□	Eye Surgery
□	Small intestine surgery	□	Breast Surgery	□	Fracture Surgery
□	Spine surgery	□	CABG	□	Hernia repair
□	Tubal ligation	□	Cholecystectomy	□	Hysterectomy
□	Colon surgery	□	Vasectomy	□	Cosmetic surgery
□	Coronary angioplasty	□	Haital Hernia		

Family History:

	Alive/Dead	Alcohol abuse	Allergies	Alzheimer's disease	Anemia	Arthritis	Asthma	Brain Cancer	Chronic Infection	Colon Cancer	Depression	Diabetes	Emphysema	Glaucoma	Hearing loss	Heart Disease	Hemochromatosis	Hhyperlipidemia	Hypertension	Lung cancer	Kidney Disease	Mental illness	Neurofibromatosis	Obesity	Osteoporosis	Seizures	Sickle cell anemia	Stroke	Thyroid Cancer	Uterine cancer	Cancer	Other
Mother																																
Father																																
Sister																																
Brother																																
Daughter																																
Son																																
Mat Aunt																																
Mat Uncle																																
Pat Aunt																																
Pat Uncle																																
MGM																																
MGF																																
PGM																																
PGF																																

Details of Onset:

Adopted: yes no

Comments:

DATE: **PATIENT NAME:** **DOB:**

Social History:

Alchohol Use □ Yes □ No

Drinks:		
	#	Glasses of wine : daily / weekly / monthly
	#	Cans/bottles of beer: daily / weekly / monthly
	#	Shots of liquor: daily / weekly / monthly
	#	Drinks containing 0.5 oz of alcohol: daily / weekly / monthly

Drug Use □ Yes □ No

Tobacco Use □ Yes □ No

Tobacco Type:	Cigarettes		Cigars		Pipe				
Packs/Day:	0.25	0.5	1	1.5	2	3	____		
Years:	0.5	1	2	3	4	5	10	15	____
Quit Date:	_____								

Implants: (type and date)

Problem list:

Immunizations:

- ✓ Close Encounter
- ✓ Date:_____Reviewed by Clinical Assistant_____
- ✓ Date:_____Reviewed by Dr._____