

Bluepoint Surgical Group

Hamid R. Pourshojae, DO
 Denis Halmi, MD, FACS
 Daniel Tran, MD, FACS
 Rajev Nain, MD
 Yohannes Matemework, DO
 Amir Moazzez, MD
 Renato Rafi, NP

Name _____ Today's Date _____ Date of Birth _____ Age _____

Reason for your visit? _____

Primary Physician _____ Referring Physician _____

SYMPTOMS Check (✓) symptoms you currently have			
General	Gastrointestinal	Heart/Lungs	Other
<input type="checkbox"/> Anxiety/Nervousness	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Depression	<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Unusual weight loss	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Muscle aches
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Joint aches
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Cough	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other:	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Fever/chills	<input type="checkbox"/> Difficulty swallowing	Skin	<input type="checkbox"/> Swelling in legs/feet
<input type="checkbox"/> Headache	<input type="checkbox"/> Heartburn/regurgitation	<input type="checkbox"/> Rash	<input type="checkbox"/> Genital/ GYN problems
<input type="checkbox"/> Memory difficulty	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Bleeding/bruising	<input type="checkbox"/> Abnl Pap/Mammogram
	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Itching	Other:
	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Jaundice/yellow skin	

PERSONAL MEDICAL HISTORY Check (✓) medical conditions you have or had in the past			
<input type="checkbox"/> Acid Reflux/ Heartburn	<input type="checkbox"/> Colitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Anorexia/bulimia	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Arthritis/gout	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Uterine bleeding/fibroid
<input type="checkbox"/> Blood clots/embolism	<input type="checkbox"/> Heart disease/attack	<input type="checkbox"/> Lung disease	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart arrhythmia	<input type="checkbox"/> Mental illness	
Other/Specify:			

PREVIOUS SURGERIES, MAJOR INJURIES, OR HOSPITALIZATIONS Please list (including year)	

NEXT PAGE ↓

