

**Northwest Surgical Specialists**  
**3355 RiverBend Drive, S-300**  
**Springfield, OR 97477**  
**(541)687-1336**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for seeking medical care today, (include symptoms and how long):

\_\_\_\_\_  
Primary Care Physician (PCP): \_\_\_\_\_

Referred By: \_\_\_\_\_

Other doctors involved in my care: \_\_\_\_\_

**Please Complete the Past Medical History and Review of Systems Scantron Forms Before  
Completing This Sheet**

**Medication List**

Present Medications: (include all prescribed medications, aspirin, and birth control pills)

\*Note- If you already have a list printed out, you may bring that list and don't fill out below. If you take more than 9 medications you will need to bring in a list written with all of the medications that do not fit in the space below.

**Medication, Dose & Times / Day:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_

**Drug Allergies: Medication & Type of Reaction:**

\_\_\_\_\_  
\_\_\_\_\_

**Vitamin / Herbal Medications:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Past Surgical History:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anal/Hemorrhoid/Rectal Surgery | <input type="checkbox"/> Aortic Surgery              | <input type="checkbox"/> Appendix Surgery    |
| <input type="checkbox"/> Breast Surgery                 | <input type="checkbox"/> C Section                   | <input type="checkbox"/> Carotid Surgery     |
| <input type="checkbox"/> Gallbladder Surgery            | <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Hernia Surgery      |
| <input type="checkbox"/> Lung Surgery                   | <input type="checkbox"/> Orthopedic Surgery          | <input type="checkbox"/> Parathyroid Surgery |
| <input type="checkbox"/> Renal Artery Surgery           | <input type="checkbox"/> Small Intestine Surg.       | <input type="checkbox"/> Spine Surgery       |
| <input type="checkbox"/> Thyroid Surgery                | <input type="checkbox"/> Uterus/Cervix/Ovary Surgery | <input type="checkbox"/> Stomach Surgery     |
| <input type="checkbox"/> Vein Surgery                   | <input type="checkbox"/> Other Surgery _____         | <input type="checkbox"/> Vascular Surgery    |
| <input type="checkbox"/> NO Previous Surgery            |  |  |