Surgical Services, PC

Patient Health History Today's Date _____

Name of Patient_____Age_____Sex_____Date of Birth_____

Did another physician refer you? Y / N if yes, whom_____

Who is your primary physician? _____

Please tell us why you are here today? _____

When did this problem start? _____ what are your symptoms_____

_____

Are you having any pain? Y/ N if yes, on a scale of 0 – 10 rate your pain. _____ (0 = no pain - 10 = severe pain)

Have you had any testing for this problem? Yes / No if yes, what testing: _____

Where was this testing done at? _____

Have you tried any medications for this problem? Yes / No if yes, what _____

Are you allergic to any <u>medications</u>? Yes / No if <u>yes</u>, please list allergy and reaction

_____ _____

_____ _____

Please list any medications you are currently taking. (Include prescription and over the counter medications)

Medication	Dosage	Frequency

List any operations you have had.

Name of surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a colonoscopy? _____ if yes, when _____where_____

Past Medical History: Check the boxes that pertain to you.

- □ Allergies
- □ Anemia
- □ Angina
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation
- □ Benign prostatic hypertrophy
- □ Blood clots
- □ Cancer _____
- □ COPD
- □ Crohn's disease
- □ Depression
- □ Diabetes
- □ Diverticular disease
- □ Gallbladder disease
- □ GERD
- □ Hepatitis C
- □ Hyperlipidemia
- □ Hypertension
- □ Irritable bowels
- □ Liver disease
- □ Migraine headaches
- □ Heart attack
- □ Osteoarthritis
- □ Osteoporosis
- □ Peptic ulcer disease
- □ Renal disease
- □ Seizure disorder
- □ Stroke
- □ Thyroid disease
- □ Vision problems
- □ other _____

Family History: Do you have a family (parents, siblings, aunts/uncles and/or grandparents) history of the following?
No relevant family history □

Hypertension □ Yes Who:_____
Heart disease □ Yes Who:_____
Diabetes □ Yes Who:_____
Cancer □ Yes Who:_____ What type: _____
Other: _____

Social History:

Marital Status _____ Are you currently employed? If yes, where _____
What is your occupation? _____Are you retired? _____
Do you currently smoke? _____ If yes, how much? _____Have you ever smoked?_____
Have you ever tried to quit? _____ If yes, how long ago did you quit? _____
Do you drink any alcohol? _____ If yes, what do you drink _____
If you drink how often do you drink? _____When was your last drink? _____
Do you use any recreational drugs? _____ If yes, what and how often _____
Do you consume any caffeine? _____ If yes, what and how many cups a day _____

***Female Patients Only:**
Who is your primary OB-Gyn doctor? _____ Age began menstruating _____
Are you currently pregnant? _____
Have you ever been pregnant? _____if yes, how many times _____, how many births did you have_____
Did you ever breast feed? _____ if yes, how long _____
Did you ever take birth control? _____if yes, how long_____
Last mammogram _____where, _____

Last PAP _____. Have you ever had a hysterectomy? _____if yes, what type_____
Do you have a personal history of breast cancer? _____ any family history? _____if yes who? _____
_____

Office Use

Date_____Ht._____Wt._____T_____P_____B/P_____