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**_____

(over)

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
- ☐ Varicose veins
- ☐ Vision problems
- ☐ other _____

Family History: Does any family members have a history of the following?

Heart Disease	Who:	Type:
High Blood Pressure	Who:	
Diabetes	Who:	Type:
Cancer	Who:	Type:

Social History:

Employment: Are you employed? ☐ Yes ☐ No If, Yes, where?_____ Occupation _____

Tobacco use:

Do you currently use nicotine? ☐ Yes ☐ No Yes, what? _____ How often _____

If yes, would you like a referral to smoking cessation class? ☐ Accepted ☐ Declined Referral made _____

If you were a former nicotine user, when did you quit completely? _____

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No

☐ 6 or more drinks per day ☐ 3-6 drinks per day ☐ 1-2 drinks per day ☐ Occasionally ☐ Never

Recreational drug use:

Do you use any street or recreational drugs?

☐ Daily ☐ Occasionally ☐ Never If yes, what recreational drugs do you use? _____

Do you consume any caffeine? IF, yes what and how often _____

***Female Patients Only:**	**YES / NO**	**IF, yes….**
Age you began menstruating:		
Are you currently pregnant?		
Have you ever been pregnant		Number of pregnancies Number of miscarriages
Did you ever take birth control?		What?
Did you ever breast feed?		How long
Last mammogram		Where,
Last pap		
Have you had a hysterectomy?		What type
Who is your OB-GYN provider?		

Office Use

Date_____T._____P._____ B/P _____ Ht._____Wt. _____BMI _____ (< 18.5 or > 25)

Your BMI is outside the parameters. Can we offer you a nutritional referral? ☐ Declined ☐ Accepted _____

In the last year have you had any of the following symptoms?

Print Name: _____

Surgical Services, PC

Constitutional:

Chills	No	Yes
Fatigue	No	Yes
Fever	No	Yes
Night sweats	No	Yes
Weight gain	No	Yes
Weight loss	No	Yes

Others _____

HEENT:

Eye pain	No	Yes
Hearing loss	No	Yes
Nasal drainage	No	Yes
Sinus pressure	No	Yes
Sore throat	No	Yes
Visual changes	No	Yes

Others _____

Respiratory:

Cough	No	Yes
Known TB exposure	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Others _____

Cardiovascular:

Chest pain/pressure	No	Yes
Edema	No	Yes
Rapid heart rate	No	Yes

Others _____

Gastrointestinal:

Abdominal pain	No	Yes
Blood in stools	No	Yes
Change in stools	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Heartburn/indigestion	No	Yes
Loss of appetite	No	Yes
Nausea	No	Yes
Vomiting	No	Yes

Others _____

Integumentary:

Mole changes	No	Yes
Rash	No	Yes
Skin lesion	No	Yes

Others _____

Musculoskeletal:

Back Pain	No	Yes
Joint pain	No	Yes
Joint swelling	No	Yes
Muscle weakness	No	Yes
Neck pain	No	Yes

Others _____

Genitourinary:

Pain with urinating	No	Yes
Blood in urine	No	Yes
Urinary frequency	No	Yes
Urinary incontinence	No	Yes
Urinary retention	No	Yes

Others _____

Reproductive:

Breast discharge	No	Yes
Breast lump	No	Yes
Hot flashes	No	Yes
Irregular menses	No	Yes
Vaginal discharge	No	Yes

Others _____

Metabolic/Endocrine:

Cold intolerance	No	Yes
Heat intolerance	No	Yes
Hirsutism	No	Yes
Extreme thirst	No	Yes
Extreme hunger	No	Yes

Others _____

Neurological:

Dizziness	No	Yes
Extremity numbness	No	Yes
Extremity weakness	No	Yes
Gait disturbance	No	Yes
Headaches	No	Yes
Memory loss	No	Yes
Seizures	No	Yes

Others _____

Psychiatric:

Anxiety	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Others _____

Hematologic/Lymphatic

Easy bleeding	No	Yes
Easy bruising	No	Yes
Lymph node swelling	No	Yes

Others _____

Immunologic

Environmental allergies	No	Yes
Food allergies	No	Yes
Seasonal allergies	No	Yes

Others _____

I certify to the best of my knowledge that the above information is correct.

Signed _____ Date _____

Patient / Representative