Health History - General Surgery

Name: _____ **DOB:** _____
Preferred Name (Nickname): _____
Pharmacy Name: _____ **Pharmacy Address:** _____
PCP/Referring Provider Name: _____
List of all doctors you see (Care Team): _____

Reason for today's visit: _____
When did your symptoms begin? _____
What triggers your symptoms? _____
What makes your symptoms better? _____
Grade your pain 0-10 (0= no pain and 10=worst pain): 10 = worst pain _____
What treatment have you had for your symptoms? _____

Was this a result of an injury? ☐ Yes ☐ No

If yes, please complete the following questions:

What type of injury? ☐ Auto ☐ Worker's Compensation ☐ Other

Date of Injury: _____

Describe how it happened? _____

If injured, is litigation ongoing? ☐ Yes ☐ No

Are you: ☐ Off Work ☐ Modified Duty ☐ Full Duty

ALLERGIES List all allergies to medications or foods and your reaction:

ALLERGY	REACTION

MEDICATIONS Please list all medicines you are currently taking (include over the counter such as vitamins):

NAME OF MEDICATION	DOSAGE	HOW OFTEN PER DAY

FEMALE PATIENTS ONLY:
Date of Last Mammogram: _____
Date of Last Menstrual Cycle: _____
Date of Last Pap Smear: _____

FAMILY HISTORY Please list any relative with the following medical problems and their relationship to you:

	Relationship
☐ Breast Cancer (Malignant Tumor of Breast)	
☐ Colon Cancer (Malignant Tumor of Colon)	
☐ Crohn's Disease	
☐ Deep Vein Thrombosis (Blood Clot)	
☐ Depression	
☐ Diabetes (Diabetes Mellitus)	
☐ Heart Attack (MI)	
☐ Hypertension (Family History of Hypertension)	
☐ Ovarian Cancer (Malignant Tumor of Ovary)	
☐ Other Cancer (Family History of Cancer)	
☐ Stroke	

SOCIAL HISTORY

Tobacco Use	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long? _____ Year Quit: _____ ☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/day
Alcohol Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? ____
Caffeine Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day _____
Live alone or with others?	☐ Alone ☐ With others
Able to care for self ?	☐ Yes ☐ No
Employment:	Occupation: Employer:
Is blood transfusion acceptable in an emergency?	☐ Yes ☐ No
Advance directive?	☐ Yes ☐ No

PAST SURGICAL HISTORY Have you ever had the following:

		Year			Year
☐ Appendectomy			☐ Hysterectomy	Partial ☐ Total ☐	
☐ Breast Biopsy	R ☐ L ☐ Both ☐		☐ Inguinal Hernia Repair	R ☐ L ☐ Both ☐	
☐ Cesarean Section			☐ Lumpectomy	R ☐ L ☐ Both ☐	
☐ Cholecystectomy (Gallbladder Removal)	Lap ☐ Open ☐		☐ Mastectomy	R ☐ L ☐ Both ☐	
			☐ Other Abdominal Surgery		
☐ Colon Cancer Surgery			☐ Prostatectomy		
☐ Colon Resection			☐ Thyroid Surgery		
☐ Colonoscopy	Facility ?		☐ Umbilical Hernia Repair		
☐ Coronary Artery Bypass Graft			☐ Ventral Hernia Repair		
☐ Hemorrhoidectomy			☐ Other Surgeries:		
☐ Hiatal Hernia Repair			☐		

Any other Medical/Surgical history/conditions, please inform the nurse.

PAST MEDICAL HISTORY Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

	Yes	No		Yes	No
AIDS	☐	☐	Heart Rhythm Problem	☐	☐
Alcoholism	☐	☐	Heart Valve Disease	☐	☐
Anemia	☐	☐	Hernia	☐	☐
Anxiety	☐	☐	High Cholesterol	☐	☐
Asthma	☐	☐	HIV	☐	☐
Bleeding Problems	☐	☐	Hypertension (High Blood Pressure)	☐	☐
Blood Clots	☐	☐	Hyperthyroidism	☐	☐
Breast Problem (Breast Lump/Pain/Discharge)	☐	☐	Hypothyroidism	☐	☐
Bowel Disease	☐	☐	Kidney or Bladder Problems	☐	☐
Cancer	☐	☐	Liver Disease / Hepatitis	☐	☐
Claustrophobic	☐	☐	Lung Disease	☐	☐
Congestive Heart Failure	☐	☐	MRSA or Antimicrobial Resistance	☐	☐
Constipation	☐	☐	Nerve Disease	☐	☐
COPD	☐	☐	Overweight / Obesity	☐	☐
Coronary Artery Disease (CAD)	☐	☐	Pacemaker	☐	☐
Depression	☐	☐	Peripheral Edema	☐	☐
Diabetes Type 1	☐	☐	Prior Blood Transfusion	☐	☐
Diabetes Type 2	☐	☐	Psychiatric Illnesses	☐	☐
Diarrhea	☐	☐	Pulmonary Embolism	☐	☐
Diverticulitis	☐	☐	Rheumatic Fever	☐	☐
Diverticulosis	☐	☐	Seizure	☐	☐
Enlarged Spleen	☐	☐	Sickle Cell Anemia	☐	☐
Epilepsy	☐	☐	Sleep Apnea	☐	☐
Gall Bladder Diseases / Stones	☐	☐	Stroke/TIA	☐	☐
Gastritis/Ulcer	☐	☐	Substance Abuse/Rehab	☐	☐
GERD / Reflux	☐	☐	Urinary Problem	☐	☐
Heart Attack (MI)	☐	☐	Other Diseases:	☐	☐
Heart Disease	☐	☐			

Review of Systems

Check all that apply:

Constitutional

- ☐ Yes ☐ No Recent Weight Change
- ☐ Yes ☐ No Decreased Appetite
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Sweats
- ☐ Yes ☐ No Fatigue

Head

- ☐ Yes ☐ No Headaches

Eyes

- ☐ Yes ☐ No Vision Changes
- ☐ Yes ☐ No Eye Disease/Injury

ENMT

- ☐ Yes ☐ No Difficulty Hearing/Ringing
- ☐ Yes ☐ No Sinus Pain
- ☐ Yes ☐ No Nosebleeds
- ☐ Yes ☐ No Nasal Discharge
- ☐ Yes ☐ No Teeth/Gum Problems

Cardiovascular

- ☐ Yes ☐ No Heart Trouble
- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Palpitations
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Swelling of Feet/ Ankles/Hands
- ☐ Yes ☐ No High Blood Pressure

Breast/Chest

- ☐ Yes ☐ No Breast Pain
- ☐ Yes ☐ No Breast Mass/Lump
- ☐ Yes ☐ No Nipple Discharge

Respiratory

- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Difficulty Breathing

Gastrointestinal

- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No Appetite Changes
- ☐ Yes ☐ No Change in Bowel Movement
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Rectal Bleeding
- ☐ Yes ☐ No Stomach Ulcer

Genitourinary

- ☐ Yes ☐ No Kidney Disease

Musculoskeletal

- ☐ Yes ☐ No Muscle Pain
- ☐ Yes ☐ No Joint Pain

Integumentary

- ☐ Yes ☐ No Rash/Mole Change
- ☐ Yes ☐ No Itching/Rash
- ☐ Yes ☐ No Change in Hair/Nails
- ☐ Yes ☐ No Change in Skin Color
- ☐ Yes ☐ No Varicose Veins

Neurologic

- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Dizziness or Lightheadedness
- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Memory Loss
- ☐ Yes ☐ No Loss of Coordination

Heme/Immunology

- ☐ Yes ☐ No Slow to Heal After Cuts
- ☐ Yes ☐ No Bleeding/Bruising Tendency
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Blood Clots
- ☐ Yes ☐ No Blood Transfusion
- ☐ Yes ☐ No Enlarged Glands

Allergic/Immunologic

- ☐ Yes ☐ No HIV

Skin Reaction or Other Adverse Reaction to:

- ☐ Yes ☐ No Penicillin/Antibiotics
- ☐ Yes ☐ No Morphine/Demerol Other Narcotics

Endocrine

- ☐ Yes ☐ No Glandular/Hormone Problem
- ☐ Yes ☐ No Thyroid Disease
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Excessive Urination

Psychiatric

- ☐ Yes ☐ No Problems with Sleep
- ☐ Yes ☐ No Memory Loss/Confusion