

## Medical/Surgical History Form

Patient Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Date:            /            / 2010

**Reason you are seeing the doctor today, please circle:**

Weight Loss Surgery      Gallbladder/Stones      Colon/intestine      Mass or Lump  
 Hernia: (groin/inguinal )      (Ventral/Belly button)      (Hiatal)  
 Acid Reflux      Barrett's Esophagus      Abdominal pain  
 Other; please write: \_\_\_\_\_

**Current Medical History. Circle the medical problem or problems you currently have or have been diagnosed with in the past.**

Heart Attack or Heart Failure	Sleep Apnea	Hepatitis B or C
History of heart <u>Stent placement</u>	Rheumatologic condition i.e. Lupus	HIV Positive
Diabetes - Non-Insulin	Pulmonary Embolism	Osteoarthritis
Diabetes - Insulin	Cirrhosis of the Liver	Reflux/GERD
High Blood Pressure	Taking Steroids (i.e. prednisone)	Back pain
High Cholesterol	Fatty Liver	Asthma
Blood Clots in legs	History of Stroke	

**Medications**

List medications you are currently taking.

**Drug Allergies**


**Past Surgical History**

Year	Type of Surgery	Complications if any

**Family History** Fill in health information about your family.

Check box if your blood relatives had any of the following:	
Disease	Relationship to You
Cancer	
Diabetes	
Heart Disease	

## Health Habits/Occupational

	Habit	How Much Per Day - Current
	Caffeine & Type	
	Tobacco	
	Street Drugs	
	Alcohol	

Check if your work exposes you to:			
	Stress		Hazardous Substances
	Heavy Lifting		Other

Have you ever had a blood transfusion?  Yes  No

If yes, please give approximate dates: \_\_\_\_\_

### **Review of Systems: Please circle the symptoms you currently have.**

#### General

- Chills
- Dizziness
- Fainting
- Fever
- Headache

#### Gastrointestinal

- Blood per rectum
- Constipation
- Diarrhea
- Nausea
- Hemorrhoids

#### Eye, Ear, Nose, Throat

- Bleeding Gums
- Double Vision
- Earache Difficulties
- Hay Fever
- Hoarseness

#### Men Only

- Breast Lump
- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sweats

#### Genito-Urinary

- Blood in Urine
- Frequent Urination
- Painful Urination

#### Muscle/Joint/Bone

Pain, weakness, numbness in:

- Arms  Hips
- Back  Legs
- Feet  Neck
- Hands  Shoulders

#### Cardiovascular

- Chest Pain
- Irregular Heart Beat
- Blood Clots

#### Skin

- Bruise Easily
- Hives
- Itching
- Change in Moles
- Sores that won't heal

#### Women Only

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump
- Nipple Discharge

**To the best of my knowledge**, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

### For Office Use:

Height: \_\_\_\_\_ inches

Weight: \_\_\_\_\_ lbs

BMI:

BP: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

HR:

RR: 14 16 18 20