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Date: _____

Patient Name: _____

Date of Birth: ____/____/____ Age: ____ Height: ____ Weight: ____

Preferred Language: _____ Race: _____ Ethnicity: _____

TO GIVE YOU THE BEST POSSIBLE MEDICAL TREATMENT AND CARE, WE MUST OBTAIN A COMPLETE MEDICAL HISTORY. ANSWERING THIS QUESTIONNAIRE WILL ASSIST YOUR SURGEON.

Referring Physician: _____ Primary Care Physician/Provider: _____

What is the reason for this visit? _____

Have you been seen in our office before? YES _____ NO _____ Date: _____

List other Doctors you are seeing and why: _____

YOUR MEDICAL HISTORY - Check all that apply:

Heart Attack High Blood Pressure AIDS
Stroke Blood Clots HIV
Diabetes Hepatitis Asthma
Oxygen Required Liters/min _____ Cancer List type: _____

YOUR PAST SURGERIES AND DATES:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY:

Relationship

Diabetes	YES ___ NO ___	_____
Cardiac Problems	YES ___ NO ___	_____
Bleeding Problems	YES ___ NO ___	_____
Cancer	YES ___ NO ___	_____
	Type: _____	_____
High Blood Pressure	YES ___ NO ___	_____
Reaction to anesthesia	YES ___ NO ___	_____
Parent's current age, if alive:	Mother _____ Father _____	_____
If deceased, age & cause of death:	Mother _____ Father _____ Cause: _____	_____

PATIENT NAME: _____

MEDICATIONS

PRESCRIBED MEDICATIONS

OVER THE COUNTER SUPPLEMENTS & HERBALS

NAME	DOSE	# YOU TAKE PER DAY	NAME OF ITEM	STRENGTH	# YOU TAKE PER DAY

ALLERGY TO ANY MEDICATIONS: YES ___ NO ___ If YES, Medication(s) _____
Reaction: _____

DO YOU HAVE A LATEX ALLERGY? YES ___ NO ___

DO YOU TAKE ANTIBIOTICS PRIOR TO PROCEDURES? YES ___ NO ___ If YES, Name of Antibiotic _____

DO YOU TAKE ANY BLOOD THINNERS? YES ___ NO ___
Aspirin Advil/Anti-Inflammatory Meds Plavix Coumadin Other: _____

DATE OF YOUR LAST COLONOSCOPY/ENDOSCOPY: _____

DATE OF YOUR LAST MAMMOGRAM: _____ **AGE OF FIRST PERIOD:** _____

DATE OF LAST PAP: _____ **ONSET OF MENOPAUSE:** _____

SOCIAL HISTORY:

Do you use alcohol? YES _____ NO _____ If yes, how often and how much _____

Do you use or chew tobacco? YES _____ NO _____ If yes, packs per day _____ Year Started _____

Have you stopped using or chewing tobacco? YES _____ NO _____ If yes, DATE QUIT? _____

Do you have a history of sexually transmitted diseases? YES _____ NO _____

Do you use recreational drugs? YES _____ NO _____ What kind? _____ How often _____

Married / Single / Other _____

of Children _____ # of Pregnancies _____ Currently pregnant? YES _____ NO _____

Retired _____ Working _____ What is/was your occupation? _____

Living situation: Home _____ Apartment _____ Assisted Living _____ Other: _____

PATIENT NAME: _____

REVIEW OF SYSTEMS (Check only those that apply to you):

GENERAL:

- Fever
- Anorexia
- Weight loss

GASTROINTESTINAL:

- Abdominal Pain
- Nausea/Vomiting
- Diarrhea
- Constipation
- Change in Bowel Habits
- Black Tarry Stools
- Bloody Stools
- Jaundice
- Gas/Bloating
- Indigestion/Heartburn
- Difficulty Swallowing
- Painful Swallowing

BREAST:

- Left Breast Lump
- Right Breast Lump
- Nipple Discharge
- Bloody Discharge from Nipple
- Breast Pain
- Abnormal Mammogram
- Breast Enlargement

CARDIOVASCULAR:

- Chest pain
- Palpitations
- Syncope
- Peripheral Edema

RESPIRATORY:

- Cough
- Shortness of Breath
- Cough up blood
- Wheezing
- Pleuritic Chest Pain

VASCULAR:

- Varicose Veins
- Leg Swelling
- Redness
- Coolness
- Pain in Legs with Walking
- Resting Leg Pain
- Pain at Night in Legs
- Blue Toe(s)

GENITOURINARY:

- Vaginal Discharge
- Incontinence
- Painful Urination
- Blood in Urine
- Urinary Frequency
- Abnormal Vaginal Bleeding
- Pelvic Pain
- Pregnancy

WOUND:

- Wound Redness
- Wound Discharge
- Wound Pain
- Opening of Wound
- Purulent Discharge
- Bleeding from Wound

SKIN:

- Suspicious Lesion
- New skin Lesion
- Changing Mole (s)
- Rash
- Itching
- History of Skin Cancer

NEUROLOGIC:

- Paralysis
- Numbness
- Seizures
- Frequent Headaches

PSYCHIATRIC:

- Depression
- Anxiety
- Nervousness
- Suicidal Ideation
- Hallucinations
- Paranoia
- Phobia
- Confusion

ENDOCRINE:

- Cold Intolerance
- Heat Intolerance
- Excessive Thirst
- Excessive Eating
- Excessive Urination
- Unusual Weight Change

BLOOD:

- Abnormal Bruising
- Bleeding
- Enlarged Lymph Nodes

MUSCULOSKELETAL:

- Back Pain
- Sciatica
- Arthritis

OTHER:

- Stoma Redness
- Pain Around Stoma
- Discharge from Stoma
- Pain from Venous Catheter
- Redness at Vascular Access Site
- Purulent Drainage from Vascular Access Site

PATIENT NAME: _____

MY MEDICAL HISTORY QUESTIONNAIRE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Date: _____

Signed: _____
(Patient or Guardian)

I HAVE REVIEWED THIS MEDICAL HISTORY WITH THE PATIENT AND/OR GUARDIAN:

Date: _____

Reviewed by: _____
(RN, LPN, MA)

Signed by: _____
(M.D.)

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MEDICAL HISTORY REVIEWED WITHIN 6 MONTHS OF LAST VISIT.

Date: _____

Patient/Guardian Initials: _____

I HAVE REVIEWED THIS MEDICAL HISTORY WITH THE PATIENT AND/OR GUARDIAN:

Reviewed by: _____
(RN, LPN, MA Initials)

M.D. Initials: _____