SURGICAL PATIENT HEALTH HISTORY UPDATE

Patient's Name:	Date:
Purpose of visit:	Date:
Date of Last Physical:	Patient's Date of Birth:
X-rays or Lab work done? ☐ Yes ☐ No	If yes, where/when?

Review of symptoms: Have you ever been treated by a physician for any of the following? Please answer **all** questions. Check "Y" for Yes or "N" for No. **Explain "Yes" answers below and on the next page. Include the year diagnosed/treated.**

Y	N		Y	N		Y	N	
General:			**Gastrointestinal:**			**Neurologic:**		
☐	☐	Weight Lose _____ lbs	☐	☐	Abdominal pain	☐	☐	Headaches
☐	☐	Weight Gain _____ lbs	☐	☐	Hepatitis	☐	☐	Weakness
Last Tetanus shot: (year)_____			☐	☐	Ulcers	☐	☐	Dizziness
Eyes:			☐	☐	Heartburn	☐	☐	Numbness/tingling
☐	☐	Glaucoma	☐	☐	Constipation	☐	☐	Seizures
☐	☐	Cataracts	☐	☐	Diarrhea	☐	☐	Strokes
☐	☐	Recent vision changes	☐	☐	Blood in stool	**Psychiatric:**		
Ears/nose/mouth/throat:			☐	☐	Colonoscopy year _____	☐	☐	Depression
☐	☐	Hearing loss	Last stool occult blood test/year_____			☐	☐	Trouble Sleeping
☐	☐	Nose bleeds	**Urinary:**			☐	☐	Schizophrenia
☐	☐	Gum problems	☐	☐	Kidney stones	☐	☐	Substance abuse
☐	☐	Sore throat	☐	☐	Painful urination			
☐	☐	Hoarseness	☐	☐	Slow/frequent urination	**Men Only:**		
☐	☐	Trouble swallowing	☐	☐	Infections	☐	☐	Prostate disease
Cardiovascular:			☐	☐	Blood in urine	☐	☐	Testicular lumps, pain
☐	☐	High blood pressure	**Musculoskeletal:**			☐	☐	Venereal disease
☐	☐	Heart attack	☐	☐	Hernias	**Women Only:**		
☐	☐	Heart catheterization	☐	☐	Fractures/dislocations	Last menstrual period started _____		
☐	☐	Chest pain	☐	☐	Arthritis	Number of Pregnancies _____		
☐	☐	Irregular heart beat	☐	☐	Muscle pain/cramps	Number of deliveries _____		
☐	☐	Shortness of breath	**Skin:**			Last pap smear (date) _____		
☐	☐	Feet / leg swelling	☐	☐	Rashes/dermatitis	☐	☐	Menstrual irregularities
☐	☐	Varicose veins	☐	☐	Changes in moles	☐	☐	Menopause, age? _____
Respiratory:			**Hematologic/lymphatic:**			☐	☐	Vaginal discharge
☐	☐	Cough	☐	☐	Easy bleeding or bruising	☐	☐	Venereal disease
☐	☐	Trouble breathing	☐	☐	Anemia	**Breast:**		
☐	☐	Wheezing	☐	☐	Blood transfusion/year _____	Last mammogram (date)_____		
☐	☐	Asthma	☐	☐	Swollen lymph nodes	☐	☐	Monthly self exams
☐	☐	Bronchitis	**Immunologic:**			☐	☐	Lumps
Endocrine			☐	☐	HIV/AIDS	☐	☐	Nipple discharge
☐	☐	Diabetes	☐	☐	Hepatitis (A, B, or C	☐	☐	Pains
☐	☐	Thyroid problems						

Family history 1st degree relative (mother, father, brother, sister, son): ☐ Yes ☐ No Colon cancer

☐ Yes ☐ No Colon polyps

Additional details about your health history:

_____

_____

_____

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Patient's Name:	Date of birth:

CURRENT MEDICATION Include dosage/frequency

Medication	Dosage	Frequency

Allergy	Reaction	Allergy	Reaction

SURGICAL HISTORY (continue on back of form, if more space is needed)

Date:	Type of Surgery:
Date:	Type of Surgery:
Date:	Type of Surgery:

Type of work you do: _____

If under 18 years old: grade in school ____ Are your immunizations up to date? ☐ Yes ☐ No

Parents age and health (if deceased, date and cause):

Father: _____ Mother: _____

What is your primary interest today?

- ☐ Information
- ☐ Second Opinion
- ☐ Surgery
- ☐ Non Surgical Treatment
- ☐ All of the above

I have carefully reviewed this questionnaire and completed it to the best of my knowledge.

_____ _____

Signature of: Patient, parent, legal guardian (circle one) Date / Time

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