

Surgical Patient Health History

This confidential questionnaire will become part of your medical record. If you do not want to answer a question, leave it blank and discuss it with your physician.

Name: _____ Date of Birth: _____ Today's Date: _____
Last First Middle

Who is your primary care physician? _____
Who referred you for your surgical evaluation? _____

What are the main reasons for your visit?

1. _____
2. _____
3. _____

Medical History

Check major, significant illnesses which apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental illness | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Bleeding/blood disorder | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pancreas disease |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Heart problems/heart attack | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer(s) _____ | <input type="checkbox"/> Heartburn/esophageal reflux (GERD) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis/jaundice | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers |

Others: _____

Surgical History

Check operations/procedures you have had and list the year:

- | | Year | | Year |
|---|-------|---|-------|
| <input type="checkbox"/> Appendix | _____ | <input type="checkbox"/> Hip surgery | _____ |
| <input type="checkbox"/> Breast lump removal or biopsy | _____ | <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Carpal tunnel | _____ | <input type="checkbox"/> Knee | _____ |
| <input type="checkbox"/> Cataract surgery | _____ | <input type="checkbox"/> Laparoscopy | _____ |
| <input type="checkbox"/> Cesarean section | _____ | <input type="checkbox"/> Nasal/sinus surgery | _____ |
| <input type="checkbox"/> Colonoscopy (looking into colon) | _____ | <input type="checkbox"/> Plastic surgery | _____ |
| <input type="checkbox"/> Colon surgery | _____ | <input type="checkbox"/> Polyp removed from intestine | _____ |
| <input type="checkbox"/> D&C | _____ | <input type="checkbox"/> Prostate surgery | _____ |
| <input type="checkbox"/> Gallbladder surgery | _____ | <input type="checkbox"/> Thyroid surgery | _____ |
| <input type="checkbox"/> EGD (looking into stomach) | _____ | <input type="checkbox"/> Tonsils/adenoids removed | _____ |
| <input type="checkbox"/> Heart catheterization/surgery | _____ | <input type="checkbox"/> Tubal ligation | _____ |
| <input type="checkbox"/> Hernia | _____ | <input type="checkbox"/> Vasectomy | _____ |

Others: _____

List any trauma/broken bones/serious accidents you have had: _____

List any other hospitalizations: _____

Medications

List all medications you are currently taking including prescription, over the counter, vitamins and herbs:

- | | | |
|----------|-----------|-----------|
| 1. _____ | 6. _____ | 11. _____ |
| 2. _____ | 7. _____ | 12. _____ |
| 3. _____ | 8. _____ | 13. _____ |
| 4. _____ | 9. _____ | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

Allergies

Please check any allergies you have and list/describe them:

- Medications _____
- Anesthetics _____
- Food _____
- Latex _____
- Tape _____
- Iodine _____
- Other _____

Family History

Are you adopted? Yes No

List the cause of death for those who have died prior to age 50 (do not include accidental deaths):

- | | |
|---------------|-----------------------|
| Father _____ | Father's Father _____ |
| Mother _____ | Father's Mother _____ |
| Sibling _____ | Mother's Father _____ |
| Sibling _____ | Mother's Mother _____ |

Check any illnesses which have occurred in a blood related brother (b), sister (s), father (f), mother (m) or grandparent (g):

- | | Who | | Who |
|---|-------|---|-------|
| <input type="checkbox"/> Alcoholism/substance abuse | _____ | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Alzheimer's/dementia | _____ | <input type="checkbox"/> Mental illness | _____ |
| <input type="checkbox"/> Breast cancer | _____ | <input type="checkbox"/> Heart attack | _____ |
| <input type="checkbox"/> Colon cancer | _____ | <input type="checkbox"/> High blood pressure | _____ |
| <input type="checkbox"/> Prostate cancer | _____ | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer(other) _____ | _____ | <input type="checkbox"/> Adverse reaction to anesthesia | _____ |

Social History

1. Occupation: _____
2. Gender: Male Female
3. Marital Status: Married Single Widowed Divorced
4. Ethnic origin: White Hispanic Black Asian American Indian
 Polynesian/Island Other: _____
5. List number of children and year of birth:
Number of sons: _____ Years of birth: _____
Number of daughters: _____ Years of birth: _____
6. Do you use or have you used tobacco? Yes No
If yes, year quit: _____ Number of years smoked: _____ Average number of packs used per day: _____
Type used: Smokeless Cigar Pipe Cigarettes
7. Do you drink alcohol? Yes No
If yes, how many drinks (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz liquor) on average do you consume during one day? _____
8. Do you follow a special diet? Low salt Low calorie Diabetic Vegetarian Low fat/cholesterol
9. How many days per week do you do exercise for at least 30 minutes? 0 1-2 3-5 6-7
10. Are you at risk for HIV/AIDS? (homosexual, bisexual, multiple sex partners, needle drug use other than insulin) Yes No Unknown

Review of Systems

Check any condition(s) which are significant problems to you:

General

- Recent change in weight
- Frequent fevers
- Frequent profound fatigue
- Frequent difficulty sleeping
- I have had a blood transfusion

Head and Neck

- Visual changes (not glasses)
- Dizziness
- Double vision
- Sinus problems
- Frequent nosebleeds
- Ear pain
- Trouble hearing
- Ringing in the ear
- Hoarseness
- Persistent sore throat
- Mouth sores
- Swollen glands

Respiratory/Lungs

- Persistent cough
- Shortness of breath
- Coughing up blood
- Wheezing
- Stop breathing during sleep

Heart/Vascular

- Chest pain/tightness
- Irregular rapid heart beat (palpitations)
- Smothering feeling at night
- Ankle swelling
- Pain in legs/calves while walking

Stomach/Bowel

- Major appetite change
- Nausea/vomiting
- Heartburn/acid in throat (GERD)
- Abdominal pain
- Diarrhea
- Constipation
- Black/bloody stools
- Vomiting blood
- Difficulty swallowing

Kidney/Bladder

- Kidney/bladder infection
- Problem with bladder control
- Difficulty starting urination
- Frequent urination or urgency
- Urination more than once nightly
- Difficulty emptying the bladder
- Burning or painful urination
- Blood in the urine
- Change in color of urine

Reproduction

- Blood in semen/sperm (men)
- Inability to have an erection (men)
- Infertility
- Sexually transmitted disease
- Menstrual problems (women)
 - Date of last period: _____
 - Age started having periods: _____
 - Age at menopause: _____
- Pregnancy problems (women)
 - Number of full term births (>36 wks): _____
 - Number of premature births (<36 wks): _____
 - Number of miscarriages/abortions: _____
 - Number of living children: _____
- Past use of birth control pills (women)
 - Length of time used: _____
- Past use of hormone replacement (women)
 - Length of time used: _____

Breast (women)

- Breast pain
- Breast lumps
- Nipple discharge
- Change in skin of breast
- Previous breast biopsy

Skeletal

- Joint pain (major)
- Back pain (major)
- Neck pain (major)
- Weakness in arms/legs
- Joint swelling/stiffness
- Deformities of the back/extremities
- Gout

Neurological

- Numbness or tingling
- Severe frequent headaches
- Abnormal coordination
- Trouble with speech
- Visual changes (shade dropping down over one eye)
- Forgetfulness/confusion
- History of seizures

Skin

- Wounds that will not heal
- Persistent rash
- Change in moles

Psychological/Social

- Feeling blue/discouraged
- High anxiety/stress
- Feeling life has no purpose
- Hearing voices
- Marital or relationship problems
- Recent major life change (move, new job, divorce, etc.)