Health History - General Surgery

Name:	DOB:
Preferred Name (Nickname):	<u> </u>
Pharmacy Name:	Pharmacy Address:
PCP/Referring Provider Name:	
List of all doctors you see (Care Team):	
When did your symptoms begin?	
What makes your symptoms better?	
Grade your pain 0-10 (0= no pain and 10=worst pain):	
Was this a result of an injury? $\ \square$ Yes $\ \square$ 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? $\ \square$ Yes $\ \square$ No	
Are you: ☐ Off Work ☐ Modified Duty ☐ Full Duty	
ALLERGIES List all allergies to medications or foods and y ALLERGY	vour reaction: REACTION
MEDICATIONS Please list all medicines you are currently to NAME OF MEDICATION	iking (include over the counter such as vitamins): DOSAGE HOW OFTEN PER DAY
FEMALE PATIENTS ONLY: Date of Last Mammogram: Date of Last Menstrual Cycle: Date of Last Pap Smear:	

□ Breast Cancer (Malignant Tumor of Denast) □ Colon Cancer (Malignant Tumor of Colon) □ Crohin's Disases □ Deep Vein Thrombosis (Blood Clot) □ Depression □ Diabetes (Diabetes Mellitus) □ Heart Attack (MI) □ Hypertension (Family History of Hypertension) □ Ovarian Cancer (Malignant Tumor of Ovary) □ Cher Cancer (Family History of Cancer) □ Stroke Social History	FAMILY HISTORY Please list any r						Relationship		
□ Colon Cancer (Malignant Tumor of Colon) □ Crohn's Disease □ Deep Vein Thrombosis (Blood Clot) □ Depression □ Diabetes (Diabetes Moliitus) □ 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 How Long? Yes □ No How Long? Use □ No Use	☐ Breast Cancer (Malignant Tumor o	of Breast)					· toralionionip		
□ Crohn's Disease □ Dep Vein Thrombosis (Blood Clot) □ Depression □ Diabetes (Diabetes Mellitus) □ Heart Attack (Mi) □ Hypertension (Family History of Hypertension) □ Ovarian Cancer (Malignant Tumor of Ovary) □ Cher Cancer (Family History of Cancer) □ Stroke SOCIAL HISTORY Tobacco Use □ Do you currently use tobacco? □ Yes □ No How Long? Year Quit: □ Gigarettes: _/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 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 □ Press □ No □ Press □ No □ Press □ No □ Press □ No □ Hysterectomy □ Partial □ Total □ □ Inguinal Hernia Repair □ Losto □ □ Casaran Section □ Umpectomy □ □ Inguinal Hernia Repair □ Notale □ Diater Abdominal Surgery □ Colono Canes Gurgery □ Prestatectomy □ Umbilical Hernia Repair □ Umbilical Hernia Repair □ Umbilical Presidence □ University □ Prestatectomy □	· · · · · · · · · · · · · · · · · · ·								
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□ Diabetes (Diabetes Mellitus) □ Hearf Attack (MI) □ Hypertension (Family History of Hypertension) □ Ovarian Cancer (Malignant Tumor of Ovary) □ Other Cancer (Family History of Cancer) □ Stroke SOCIAL HISTORY Do you currently use tobacco? Yes No Did you use tobacco in your past? Yes No Did you use tobacco in your past? Yes No How Long? Yes Oldy Yes Oldy Yes Oldy		,							
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□ Ovarian Cancer (Malignant Tumor of Ovary) □ Other Cancer (Family History of Cancer) □ Stroke □ Oyou currently use tobacco? Yes □ No □ No □ Oyou currently use tobacco? □ Do you use tobacco in your past? □ Yes □ No □ No □ Oyou currently use tobacco? □ Yes □ No □ No □ Oyou currently use tobacco? □ Cagarettes □ day □ Chew □ day □ Cigars □ day □ Cagarettes □ 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 male)? □ Independent □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcohol Intake □ None □ Occasional □ Moderate □ Heavy □ Alcoholo Intake □ None □ Occasional □ Moderate □ Heavy □ Alcoholo Intake □ None □ Occasional □ Moderate □ Heavy	'								
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Alcohol Intake None Occasional Moderate Heavy How many days in the past year have you had a heavy drinking consumption (4+ female male)? None Occasional Moderate Heavy # of cups/cans per day	Did you use tobac How Long?				/our past? □ Yes □ No Year Quit:	V			
# of cups/cans per day	Alcohol Intake ☐ None ☐ Occas How many days i			asional [asional Moderate Heavy				
Able to care for self? Yes No No Employer: Employer: Employer: Section Yes No No No No No No No N	Caffeine Intake ☐ None ☐ Occa								
Employment: Occupation: Employer: Is blood transfusion acceptable in an emergency? Advance directive?				n others					
s blood transfusion acceptable in an emergency? Advance directive? PAST SURGICAL HISTORY Have you ever had the following: PAST SURGICAL HISTORY Have you ever had the following: Year Appendectomy Breast Biopsy Cesarean Section Cholecystectomy Gallbladder Removal) Colon Cancer Surgery Colon Resection Colon Resection Colonoscopy Facility? Umbilical Hernia Repair Verar No Year Hemorrhoidectomy Have you ever had the following: Year Year Hemorrhoidectomy Histel Hernia Repair Ventral Hernia Repair Other Surgeries:	Able to care for self ?]	□ Yes □ No						
Advance directive? Yes No					Employer:				
PAST SURGICAL HISTORY Have you ever had the following: Year	Is blood transfusion acceptable in an ☐ Yes ☐ No emergency?								
Year Appendectomy Breast Biopsy R □ L □ Both □ □ Inguinal Hernia Repair Lumpectomy Cesarean Section □ Lumpectomy R □ L □ Both □ □ Lumpectomy R □ L □ Both □ □ Other Abdominal Surgery □ Colon Cancer Surgery □ Colon Resection □ Thyroid Surgery □ Colonoscopy Facility? □ Umbilical Hernia Repair □ Ventral Hernia Repair □ Other Surgeries: □ Other Surgeries:									
Breast Biopsy R L Both L Both L Lumpectomy R L Both L Both Lumpectomy R L Both L Both Lumpectomy R Lap Dopen Lap Dopen Dother Abdominal Surgery Prostatectomy Dother Abdominal Surgery Prostatectomy Thyroid Surgery Dumblical Hernia Repair Ventral Hernia Repair Dother Surgeries:		ve you eve	er had the follov					Yea	
□ Cesarean Section □ Lumpectomy R □ L □ Both □ □ Cholecystectomy (Gallbladder Removal) □ Mastectomy R □ L □ Both □ □ Colon Cancer Surgery □ Other Abdominal Surgery □ Colon Resection □ Prostatectomy □ Colonoscopy □ Thyroid Surgery □ Coronary Artery Bypass Graft □ Umbilical Hernia Repair □ Hemorrhoidectomy □ Other Surgeries:	• • • • • • • • • • • • • • • • • • • •				, ,				
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□ Colon Cancer Surgery □ Prostatectomy □ Colon Resection □ Thyroid Surgery □ Colonoscopy □ Umbilical Hernia Repair □ Coronary Artery Bypass Graft □ Ventral Hernia Repair □ Hemorrhoidectomy □ Other Surgeries:				☐ Mastectomy	R [□ L □ Both □			
Colon Resection ☐ Thyroid Surgery ☐ Colonoscopy ☐ Umbilical Hernia Repair ☐ Ventral Hernia Repair ☐ Hemorrhoidectomy ☐ Other Surgeries:	,				☐ Other Abdominal Surgery				
Colonoscopy Gracility? Umbilical Hernia Repair Ventral Hernia Repair Other Surgeries:					☐ Prostatectomy				
☐ Coronary Artery Bypass Graft ☐ Ventral Hernia Repair ☐ Other Surgeries: ☐ Uthorical Hernia Repair ☐ Other Surgeries: ☐ Other				☐ Thyroid Surgery					
☐ Hemorrhoidectomy ☐ Other Surgeries:				☐ Umbilical Hernia Repair					
Histol Harnia Panair	, , , ,			□ Ventral Hernia Repair					
□ Hiatal Hernia Repair					☐ Other Surgeries:				
· · · · · · · · · · · · · · · · · · ·	□ Hiatal Hernia Repair								

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:			Respiratory	Heme/Immunology		
Constitutional ☐ Ye		☐ Yes ☐ No	Wheezing	☐ Yes ☐ N	Slow to Heal After Cuts	
☐ Yes ☐ No	Recent Weight Change	☐ Yes ☐ No	Cough	☐ Yes ☐ N	Bleeding/Bruising Tendency	
☐ Yes ☐ No	Decreased Appetite	☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ N	o Anemia	
☐ Yes ☐ No	Fever	(Gastrointestinal	☐ Yes ☐ N	Blood Clots	
☐ Yes ☐ No	Sweats	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ N	Blood Transfusion	
☐ Yes ☐ No	Fatigue	☐ Yes ☐ No	Appetite Changes	☐ Yes ☐ N	o Enlarged Glands	
	Head	☐ Yes ☐ No	Change in Bowel		llergic/Immunologic	
☐ Yes ☐ No	Headaches		Movement	☐ Yes ☐ N	o HIV	
	Eyes	☐ Yes ☐ No	Nausea		Skin Reaction or Other	
☐ Yes ☐ No	Vision Changes	☐ Yes ☐ No	Vomiting		Adverse Reaction to:	
☐ Yes ☐ No	Eye Disease/Injury	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ N		
	ENMT	☐ Yes ☐ No	Constipation	☐ Yes ☐ N		
☐ Yes ☐ No	Difficulty Hearing/Ringing	☐ Yes ☐ No	Rectal Bleeding		Other Narcotics	
☐ Yes ☐ No	Sinus Pain	☐ Yes ☐ No	Stomach Ulcer		Endocrine	
☐ Yes ☐ No	Nosebleeds		Genitourinary	☐ Yes ☐ N		
☐ Yes ☐ No	Nasal Discharge	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ N	,	
☐ Yes ☐ No	Teeth/Gum Problems	-	Musculoskeletal	☐ Yes ☐ N		
Ca	ırdiovascular	☐ Yes ☐ No	Muscle Pain	☐ Yes ☐ N		
☐ Yes ☐ No	Heart Trouble	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ N		
☐ Yes ☐ No	Chest Pain		Integumentary		Psychiatric	
☐ Yes ☐ No	Palpitations	☐ Yes ☐ No	Rash/Mole Change	☐ Yes ☐ N		
☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Itching/Rash	☐ Yes ☐ N	Memory Loss/Confusion	
☐ Yes ☐ No	Swelling of Feet/	☐ Yes ☐ No	Change in Hair/Nails			
	Ankles/Hands	☐ Yes ☐ No	Change in Skin Color			
☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Varicose Veins			
В	reast/Chest	Neurologic				
☐ Yes ☐ No	Breast Pain	☐ Yes ☐ No	Headaches			
☐ Yes ☐ No	Breast Mass/Lump	☐ Yes ☐ No	Dizziness or			
☐ Yes ☐ No	Nipple Discharge		Lightheadedness			
		☐ Yes ☐ No	Numbness			
		☐ Yes ☐ No	Memory Loss			
		☐ Yes ☐ No	Loss of Coordination			