PATIENT HISTORY QUESTIONNAIRE

Your answers on this form will help your surgeon understand your medical concerns and conditions better. This form will be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **THANK YOU!**

TODAY'S DATE ___________________________

NAME ____ AGE ___________________ DOB ______________________

REASONS FOR TODAY'S VISIT ____

Approximate date symptoms started ____

IS VISIT RELATED TO WORK OR AUTO INJURY? ☐ YES ☐ NO Date of Injury _____________________________________

ARE YOU ALLERGIC TO ANY MEDICINES? ☐ YES ☐ NO If yes, please list: ____

____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Do you take any aspirin products or blood thinners? ☐ YES ☐ NO If yes, please include them in the list below

Are you or have you recently been on steroids? ☐ YES ☐ NO If yes, how much? ______________________________________

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

SOCIAL HISTORY:

Do you smoke? ☐ YES ☐ NO If yes, how much and how long? ____

Do you drink alcohol? ☐ YES ☐ NO If yes, how much? ____

Do you use recreational drugs? ☐ YES ☐ NO If yes, kind and how often ____

FAMILY HISTORY:

Breast Cancer ☐ YES ☐ NO Who _______________ Diabetes ☐ YES ☐ NO Who _________________

Colon Cancer ☐ YES ☐ NO Who _______________ Heart Disease ☐ YES ☐ NO Who _________________

Melanoma ☐ YES ☐ NO Who _______________ Hypertension ☐ YES ☐ NO Who _________________

Other Cancers ☐ YES ☐ NO Who _______________ Other ____

PLEASE LIST ALL PAST OPERATIONS AND SERIOUS ILLNESSES:

Operation or illness	Date	Location

Recent x-rays, labs or tests related to the present illness

____ ____________________________ ________________________________

____ ____________________________ ________________________________

PLEASE INDICATE WITH A (√) THOSE MEDICAL CONDITIONS THAT YOU HAVE:

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep apnea
- ☐ High blood pressure
- ☐ Heart arrhythmia
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Seizures
- ☐ Stroke
- ☐ Lupus
- ☐ Hepatitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel
- ☐ Cancer: _______________ _______________________
- ☐ Other: ________________ _______________________

REVIEW OF SYSTEMS

PATIENT NAME ____

Please check (√) "yes" or "no" to each problem on the list below:

CONSTITUTIONAL
- ☐ No ☐ Yes Good general health lately
- ☐ No ☐ Yes Recent weight change
- ☐ No ☐ Yes Fevers/night sweats
- ☐ No ☐ Yes Fatigue/weakness
- ☐ No ☐ Yes Headaches

EYES
- ☐ No ☐ Yes Change in vision
- ☐ No ☐ Yes Eye disease or injury

EARS/NOSE/THROAT/MOUTH
- ☐ No ☐ Yes Difficult hearing/ringing in ears
- ☐ No ☐ Yes Problems with teeth or gums
- ☐ No ☐ Yes Hoarseness

CARDIOVASCULAR
- ☐ No ☐ Yes Heart trouble
- ☐ No ☐ Yes Chest pain or angina
- ☐ No ☐ Yes Palpitation
- ☐ No ☐ Yes Shortness of breath when lying flat
- ☐ No ☐ Yes Swelling of feet, ankles, or hands
- ☐ No ☐ Yes High blood pressure

CHEST/BREAST
- ☐ No ☐ Yes Breast lump
- ☐ No ☐ Yes Breast pain
- ☐ No ☐ Yes Nipple discharge

RESPIRATORY
- ☐ No ☐ Yes Cough/wheeze
- ☐ No ☐ Yes Difficulty breathing

GASTROINTESTINAL
- ☐ No ☐ Yes Loss of appetite
- ☐ No ☐ Yes Change in bowel movements
- ☐ No ☐ Yes Nausea or vomiting
- ☐ No ☐ Yes Frequent diarrhea or constipation
- ☐ No ☐ Yes Liver disease
- ☐ No ☐ Yes Rectal bleeding or blood in stools
- ☐ No ☐ Yes Abdominal pain
- ☐ No ☐ Yes Ulcer (stomach)

GENITOURINARY
- ☐ No ☐ Yes Kidney disease
- ☐ No ☐ Yes Difficulty urinating

MUSCULOSKELETAL
- ☐ No ☐ Yes Muscle/joint pain

GYNECOLOGICAL
- ☐ No ☐ Yes Abnormal vaginal discharge
- ☐ No ☐ Yes Abnormal uterine bleeding
- ☐ No ☐ Yes Oral Contraceptive use
- ☐ No ☐ Yes Hormone replacement therapy

Age of first menses: ______________

Age of menopause: _______________

No. of pregnancies: _______ Age at first: _______

SKIN
- ☐ No ☐ Yes Mole change
- ☐ No ☐ Yes Rash or itching
- ☐ No ☐ Yes Change in hair or nails

NEUROLOGICAL
- ☐ No ☐ Yes Dizziness/lightheadedness
- ☐ No ☐ Yes Numbness
- ☐ No ☐ Yes Seizures
- ☐ No ☐ Yes Loss of coordination

BLOOD/LYMPHATIC
- ☐ No ☐ Yes Bleeding or bruising tendency
- ☐ No ☐ Yes Anemia
- ☐ No ☐ Yes Blood clots or pulmonary emboli
- ☐ No ☐ Yes Sickle cell anemia or trait
- ☐ No ☐ Yes History of blood transfusion
- ☐ No ☐ Yes Enlarged glands

ALLERGIC/IMMUNOLOGIC
- ☐ No ☐ Yes HIV or AIDS
- ☐ No ☐ Yes Tuberculosis

History of skin reaction or other adverse reaction to:
- ☐ No ☐ Yes Latex
- ☐ No ☐ Yes Tapes or adhesives
- ☐ No ☐ Yes Iodine, seafood or x-ray dyes

ENDOCRINE
- ☐ No ☐ Yes Glandular or hormone problem
- ☐ No ☐ Yes Goiter
- ☐ No ☐ Yes Diabetes: ☐ insulin or ☐ non-insulin
- ☐ No ☐ Yes Excessive thirst or urination

PSYCHIATRIC
- ☐ No ☐ Yes Memory loss or confusion
- ☐ No ☐ Yes Problems with sleep

OTHER
- ☐ No ☐ Yes Previous anesthesia problems
- ☐ No ☐ Yes Other ____________________________

FOR PHYSICIAN USE ONLY-DO NOT WRITE IN THIS BOX

Physician reviewer: ____ Date: _________________