# Medical/Surgical History Form

Patient Name: ______________________________ Date: / /2011
Age: ___________ Birth date: ______________ Email: ______________________________

**Reason you are seeing the doctor today, please circle:**

**Weight Loss Surgery** **Gallbladder/Stones** **Colon/intestine** **Mass or Lump**
**Hernia: (groin/inguinal )** **(Ventral/Belly button)** **(Hiatal)**
**Acid Reflux** **Barrett's Esophagus** **Abdominal pain**
**Other; please write:**____________________________________

## Current Medical History. Circle the medical problem or problems you currently have or have been diagnosed with in the past.

**Heart Attack or Heart Failure**
**History of heart Stent placement**
**Diabetes - Non-Insulin**
**Diabetes - Insulin**
**High Blood Pressure**
**High Cholesterol**
**Blood Clots in legs**
**Sleep Apnea**
**Rheumatologic condition i.e. Lupus**
**Pulmonary Embolism**
**Cirrhosis of the Liver**
**Taking Steroids (i.e. prednisone)**
**Fatty Liver**
**History of Stroke**
**Hepatitis B or C**
**HIV Positive**
**Osteoarthritis**
**Reflux/GERD**
**Back pain**
**Asthma**

## Medications

List medications you are currently taking.

______________________________
______________________________
______________________________
______________________________

## Drug Allergies

______________________
______________________
______________________

## Past Surgical History

| Year | Type of Surgery | Complications if any |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

## Family History

Fill in health information about your family.

| Check box if your blood relatives had any of the following: | Disease | Relationship to You |
| --- | --- | --- |
| | Cancer | |
| | Diabetes | |
| | Heart Disease | |
| | | |

## Health Habits/Occupational

| | Habit | How Much Per Day - Current |
|---|---|---|
| | Caffeine & Type | |
| | Tobacco | |
| | Street Drugs | |
| | Alcohol | |

| Check if your work exposes you to: | | | |
|---|---|---|---|
| | Stress | | Hazardous Substances |
| | Heavy Lifting | | Other |

**Have you ever had a blood transfusion?** ☐ Yes ☐ No
If yes, please give approximate dates: ___________________

## Review of Systems: Please circle the symptoms you currently have.

**General**
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache

**Gastrointestinal**
- ☐ Blood per rectum
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Hemorrhoids

**Eye, Ear, Nose, Throat**
- ☐ Bleeding Gums
- ☐ Double Vision
- ☐ Earache Difficulties
- ☐ Hay Fever
- ☐ Hoarseness

**Men Only**
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sweats

**Genito-Urinary**
- Blood in Urine
- Frequent Urination
- Painful Urination

**Muscle/Joint/Bone**
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

**Cardiovascular**
- ☐Chest Pain
- ☐Irregular Heart Beat
- ☐ Blood Clots
- ☐

**Skin**
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- Change in Moles
- ☐ Sores that won't heal

**Women Only**
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐

**To the best of my knowledge**, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_________________________________________ _________________________
Signature of Patient, Parent, Guardian or Personal Representative Date

_________________________________________ _________________________
Please Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

## For Office Use:

Height: inches

Weight: lbs

BMI:

BP: Systolic Diastolic

HR:

RR: 14 16 18 20