

# Medical History Form

## Consulting Surgeons

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_\_\_

Reason for visit today \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Physician \_\_\_\_\_

Any other physicians seen regularly: \_\_\_\_\_

For what reasons: \_\_\_\_\_

### MEDICATION (prescription, supplements, vitamins and over the counter)

Name of medication	Reason for taking	Name of medication	Reason for taking

Please circle if you take any of the following: Coumadin Plavix Lovenox Aspirin Ibuprofen

### FAMILY HISTORY (e.g. cancer or hereditary diseases)

Family Member	Disease	Cause of death

### ALLERGIES to medication:

Yes \_\_\_ (Please list below) No \_\_\_

Name of Medication	Reaction

### PAST SURGICAL HISTORY:

SURGERY	DATE	SURGERY	DATE

### SOCIAL HISTORY

Marital status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_

Do you have children? Yes \_\_\_ No \_\_\_ If yes, how many: daughters \_\_\_ sons \_\_\_

Who do you live with? \_\_\_\_\_

Do you work? Yes \_\_\_ No \_\_\_ What type of work do you do or did you do if you are retired? \_\_\_\_\_

Do you smoke or have you ever smoked cigars/cigarettes? Yes \_\_\_ No \_\_\_ How many per day? \_\_\_\_\_  
 For how long? \_\_\_\_\_ Year quit (if applicable) \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_ How many drinks per week? \_\_\_\_\_

Have you recently used recreational drugs? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_

Do you consume caffeine? Yes \_\_\_ No \_\_\_ What type? \_\_\_\_\_

### HEALTH MAINTENANCE

Have you had a colonoscopy? Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_ Results: Normal \_\_\_ Abnormal \_\_\_

Have you had a mammogram? Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_ Results: Normal \_\_\_ Abnormal \_\_\_

Did you ever have a breast biopsy? Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_ Side: L \_\_\_ R \_\_\_

Results: Normal \_\_\_ Abnormal \_\_\_ Explain: \_\_\_\_\_

## GYNECOLOGIC HISTORY

Date of last menstrual cycle \_\_\_\_\_ Are you regular? Yes \_\_\_ No \_\_\_ Age at menopause \_\_\_\_\_  
Date of last exam \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ Age at birth of 1<sup>st</sup> child \_\_\_\_\_  
Age at 1<sup>st</sup> period \_\_\_\_\_ How many sisters, daughters or mother has had breast cancer? \_\_\_\_\_  
Vaginal discharge Y \_\_\_ N \_\_\_ Abnormally heavy menses Y \_\_\_ N \_\_\_ Pain with menses Y \_\_\_ N \_\_\_

## HEALTH PROBLEMS (Please circle those that apply to you)

Glaucoma	Heart failure	Previous heart attack	Date: _____
Heart murmur	Irregular heart beat	Rheumatic fever	
Diabetes	High cholesterol	High blood pressure	
Asthma	Tuberculosis	Bronchitis	
Pneumonia	Emphysema	Sleep Apnea	
Arthritis	Thyroid disorder	Gallstones	
Reflux	Hiatal hernia	Peptic ulcer disease	
Hepatitis	Cirrhosis	Diverticulosis	
Hernia	Hemorrhoids	Colitis	
Kidney failure	Kidney stones	Incontinence	
Impotence	Stroke	Headaches	
Anxiety	Depression	Anemia	
HIV/AIDS	No known health problems	Cancer (Type of cancer _____)	
Other _____			

Do you have any metal implants? If yes please specify \_\_\_\_\_

## Please circle any of the following symptoms you have experienced in the past 6 months:

### CONSTITUTIONAL

Fever  
Weight loss  
Fatigue  
Loss or change of appetite  
Night sweats

### EYES, EARS, NOSE, & MOUTH

Discharge from eyes  
Vision loss  
Discharge from ears  
Hearing loss  
Facial pain/sinusitis  
Tooth pain  
Hoarseness  
Headache

### RESPIRATORY

Wheezing  
Blood in sputum  
Chronic cough  
Shortness of breath  
Pleurisy  
Frequent URI  
Snoring

### CARDIOVASCULAR

Chest pain  
Palpitations  
Pain in legs while walking  
Pain or swelling in extremities

### GASTROINTESTINAL

Abdominal pain  
Diarrhea or constipation  
Nausea  
Vomiting/blood in vomit  
Blood in stool/black stool  
Jaundice  
Indigestion/Heartburn  
Difficulty swallowing  
Excessive bloating  
Excessive belching or flatulence  
Difficulty holding stool

### GENITOURINARY

Blood in urine  
Burning with urination  
Frequent urination  
Frequent urinary infections  
Change in urine color  
Decreased stream  
Groin mass  
REPRODUCTIVE  
Nipple discharge  
Breast mass/breast pain  
Testicular mass  
Testicular pain

### DERMATOLOGIC

Rash  
Itching  
Hair loss

### ENDOCRINE

Cold intolerance  
Heat intolerance  
Excessive thirst  
Excessive hunger  
Excessive urination

### NEUROLOGIC/PSYCH

Loss of consciousness  
Numbness/tingling: Location \_\_\_\_\_  
Seizures  
Dizziness  
Change in mood

### MUSCULOSKELETAL

Bone pain  
Joint pain  
Back pain  
Weakness

### HEMATOLOGIC

Blood clots Date: \_\_\_\_\_  
Easy bleeding  
Easy bruising  
Bleeding gums

### IMMUNOLOGIC

Environmental allergies  
Food allergies  
All negative

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_ Last updated 2/23/2010