MEDICAL HISTORY FORM

Consulting Surgeons

Name: _____ **DOB:** _____ **Today's Date:** _____

Reason for visit today: _____ **Height:** _____ **Weight:** _____

Referring Physician: _____ **Primary Physician:** _____

Other physician's 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**

Pharmacy: _____ **Pharmacy Address:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

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

Please indicate MATERNAL or PATERNAL

Family member	Disease	Cause of death

ALLERGIES TO MEDICATIONS:

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 daughter(s)_____ son(s)_____

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 ever smoked cigars/cigarettes? Yes_____ No_____ How many per day? _____

For how long?_____ Year quit (if applicable):_____

Do you drink alcohol? Yes_____ No_____ How may 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_____

Have you ever had a breast biopsy? Yes_____ No_____ When?_____ Side: L_____ R_____

Results: Normal_____ Abnormal_____ Explain: _____

GYNECOLOGICAL 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 1st child:_____

Age at 1st period:_____ How many sisters, daughters or mother has had breast cancer?_____

Vaginal discharge? Yes____ No____ Abnormally heavy menses? Yes____ No____ Pain with menses? Yes____ No____

HEALTH PROBLEMS (Please circle those that apply to you)

Glaucoma
Heart Murmur
Diabetes
Asthma
Pneumonia
Arthritis
Reflux
Hepatitis
Hernia
Kidney Failure
Impotence
Anxiety
HIV/AIDS

Heart failure
Irregular heart beat
High cholesterol
Tuberculosis
Emphysema
Thyroid disorder
Hiatal Hernia
Cirrhosis
Hemorrhoids
Kidney Stones
Stroke
Depression
Cancer Type of cancer:_____

Previous heart attack Date:_____
Rheumatic fever
High blood pressure
Bronchitis
Sleep Apnea
Gallstones
Peptic ulcer disease
Diverticulosis
Colitis
Incontinence
Headaches
Anemia
NO KNOWN HEALTH PROBLEMS

Other:_____

Do you have any metal implants? Yes_____ No_____ If yes, please specify:_____

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERICED IN THE LAST 6 MONTHS:

CONSTITUTIONAL
Fever
Weight Loss
Fatigue
Loss or change of appetite
Night sweats

ENDOCRINE
Cold intolerance
Heat intolerance
Excessive Thirst
Excessive Hunger
Excessive Urination

IMMUNOLOGIC
Environmental allergies
Food allergies

RESPIRATORY
Wheezing
Blood in sputum
Chronic cough
Shortness of breath

REPRODUCTIVE
Nipple discharge
Breast mass/breast pain
Testicular mass
Testicular pain

HEMATOLOGIC
Blood clots Date:_____
Easy bleeding
Easy bruising
Bleeding gums

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

MUSCULOSKELETAL
Bone pain
Joint pain
Back pain
Weakness

NEUROLOGIC/PSYCH
Loss of consciousness
Numbness/Tingling Location:_____
Seizures
Dizziness
Change in mood

GASTROINTESTINAL
Abdominal pain
Diarrhea/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

DERMATOLOGIC
Rash
Itching
Hair loss

EYES, EARS, NOSE & MOUTH
Discharge from eyes
Vision loss
Discharge from ears
Hearing loss
Facial pain/Sinusitis
Tooth pain
Hoarseness
Headache

GENITOURINARY
Blood in urine
Burning with urination
Frequent urination
Frequent urinary infection
Change in urine color
Decreased stream
Groin mass

ALL NEGATIVE/NO SYMPTOMS

Patient signature:_____ Date:_____