Health History

Patient Name _____ **Date of Birth** _____

Reason for visit

_____

Past Medical History

Have you ever had the following? (Mark all that apply)

☐ Alcoholism	☐ Cancer	☐ Endocarditis	☐ MRSA/VRE
☐ Allergies	☐ Cardiac Arrest	☐ Gallbladder disease	☐ Myocardial infarction
☐ Anemia	☐ Cardiac dysrhythmias	☐ GERD	☐ Osteoarthritis
☐ Angina	☐ Cardiac valvular disease	☐ Hemoglobinopathy	☐ Osteoporosis
☐ Anxiety	☐ Cerebrovascular accident	☐ Hepatitis C	☐ Peptic ulcer disease
☐ Arthritis	☐ COPD	☐ HIV/AIDS	☐ Psychosis
☐ Asthma	☐ Coronary artery disease	☐ Hyperlipidemia	☐ Pulmonary fibrosis
☐ Atrial fibrillation	☐ Crohn's disease	☐ Hypertension	☐ Radiation
☐ Benign prostatic hypertrophy	☐ Dementia	☐ Inflammatory bowel disease	☐ Renal disease
☐ Bleeding disorder	☐ Depression	☐ Liver disease	☐ Seizure disorder
☐ Blood clots	☐ Diabetes	☐ Malignant hyperthermia	☐ Sleep apnea
☐ Blood transfusion	☐ DVT	☐ Migraine headaches	☐ Thyroid disease

Previous Hospitalizations/Surgeries/Serious Illnesses

Have you ever had the following? (Mark all that apply and specify dates)

	Date		Date		Date		Date
☐ AICD Insertion		☐ Cyst/lipoma removal		☐ Pacemaker		☐ Mastectomy	
☐ Angioplasty		☐ ESWL		☐ Pilonidal cyst removal		☐ Myomectomy	
☐ Angio w/ stent		☐ Gender reassignment		☐ Small bowel resection		☐ Penile implant	
☐ Appendectomy		☐ Hemorrhoidectomy		☐ Thyroidectomy		☐ Prostate biopsy	
☐ Arthroscopy knee		☐ Hernia surgery		☐ TIF		☐ TAH/BSO	
☐ Bariatric surgery		☐ Hip replacement		☐ Tonsillectomy		☐ TURP	
☐ Back surgery		☐ Laparoscopy				☐ Vaginal hysterectomy	
☐ Breast biopsy		☐ Laparotomy		**Gender Specific**		☐ Vasectomy	
☐ CABG		☐ LASIK		☐ Bilateral tubal ligation			
☐ Carpal tunnel release		☐ LINX		☐ Breast augmentation			
☐ Cataract extraction		☐ Liver biopsy		☐ Breast reduction			
☐ Cholecystectomy		☐ Nephrectomy		☐ Cesarean section			
☐ Colectomy		☐ Organ Transplant		☐ D and C			
☐ Colostomy		☐ ORIF		☐ Hysterectomy			

List any others not addressed above: When: Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications (include non-prescription)

_____

_____

Drug allergies

_____

SURGICAL ASSOCIATES MANSFIELD

Methodist MEDICAL GROUP

Review of Systems

Have you had any of the following in the last 3 months? (Mark all that apply)

Constitutional Symptoms
- ☐ Good general health
- ☐ Recent weight change
- ☐ Headaches
- ☐ Fever
- ☐ Fatigue

Cardiovascular
- ☐ Arrhythmia
- ☐ Chest pain
- ☐ Palpitation
- ☐ Shortness of breath
- ☐ Swelling of feet, ankles, or hands

Genitourinary
- ☐ Back pain
- ☐ Change in urine color
- ☐ Cloudy urine
- ☐ Decreased stream
- ☐ Decreased output
- ☐ Foul urine odor
- ☐ Frequent urination
- ☐ Groin mass
- ☐ Urgency
- ☐ Incontinence

Neuro/Psychiatric
- ☐ Dizziness
- ☐ Weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Incontinence
- ☐ Light headedness
- ☐ Loss of consciousness
- ☐ Memory impairment
- ☐ Seizures
- ☐ Speech changes
- ☐ Tremors
- ☐ Vertigo
- ☐ Visual changes

Hematologic
- ☐ Easy bleeding
- ☐ Easy bruising

Eyes/Ears/Nose/Mouth/Throat
- ☐ Eye disease or injury
- ☐ Blurred or double vision
- ☐ Ear discharge
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Vertigo
- ☐ Nasal drainage
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Voice change
- ☐ Swollen glands in neck
- ☐ Snoring
- ☐ Tooth pain

Vascular
- ☐ Cooling extremities
- ☐ Swelling extremities

Reproductive
- ☐ Pre-menopausal
- ☐ Menopausal
- ☐ Post-menopausal
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Breast pain
- ☐ Fibroids
- ☐ Ovarian cysts

Dermatologic
- ☐ Acne
- ☐ Allergies
- ☐ Hair loss
- ☐ Nail changes
- ☐ Photosensitivity
- ☐ Pigment change
- ☐ Pruritus
- ☐ Rash
- ☐ Change in mole
- ☐ Skin lesion

Immunologic
- ☐ Hives
- ☐ Asthma

Respiratory/Thorax
- ☐ Persistent cough or throat clearing
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Wheezing
- ☐ Frequent upper respiratory infections
- ☐ Known TB exposure
- ☐ Spitting up blood

Gastrointestinal
- ☐ Abdominal mass
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Blood in stool
- ☐ Change in appetite
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Decreased appetite
- ☐ Diarrhea
- ☐ Fecal incontinence
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Increased appetite
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Reflux
- ☐ Vomiting
- ☐ Weight loss

Metabolic/Endocrine
- ☐ Generalized weakness
- ☐ Hair loss
- ☐ Hypoglycemia
- ☐ Tremors
- ☐ Voice change

Musculoskeletal
- ☐ Back pain
- ☐ Bone/joint symptoms
- ☐ Muscle weakness
- ☐ Neck stiffness

Social History

Occupation: _____Hours/week: _____Are you satisfied with your job? _____

Alcohol (drinks per day): _____ Caffeine (drinks per day): _____

Tobacco smoking (cigarettes/day): _____ Years: _____ Year quit: _____

Tobacco chewing (cans/day): _____ Years: _____ Year quit: _____

Recreational drugs _____ Last used: _____

Do you follow a particular diet? (please explain): _____

Do you regularly exercise? If yes, how often: _____

Family History

Has any relative has suffered any of the following? (Mark all that apply and indicate which relative)

F- Father M- Mother B- Brother S- Sister C- Child

☐ Alcoholism	F M B S C R	☐ Diabetes	F M B S C R	☐ Obesity	F M B S C R
☐ Anemia	F M B S C R	☐ Glaucoma	F M B S C R	☐ Osteoporosis	F M B S C R
☐ Arthritis	F M B S C R	☐ Heart Disease	F M B S C R	☐ Seizures	F M B S C R
☐ Asthma	F M B S C R	☐ High Cholesterol	F M B S C R	☐ Stroke	F M B S C R
☐ Blood Clots	F M B S C R	☐ Hypertension	F M B S C R	☐ Thyroid Disease	F M B S C R
☐ Cancer	F M B S C R	☐ Migraine	F M B S C R		