

HISTORY & PHYSICAL

PATIENT INFORMATION

(Please Print)

Today's Date _____ Male

Patient Name _____ Date of Birth _____ Age _____ Female

Do you have an Advance Directive (Living Will)? No Yes (If Yes, please provide a copy.)

REASON FOR VISIT

What is your surgical problem? _____

What are your symptoms? _____ When did they start? _____

Referring Physician _____ Other physicians you are seeing _____

MEDICAL HISTORY

List Operations (Include Date) None

Other Medical Conditions None

1.) _____

1.) _____

2.) _____

2.) _____

3.) _____

3.) _____

4.) _____

4.) _____

Medications (State amount taken daily) None

Allergies (Please list below) None

1.) Aspirin, Advil, Arthritis Med. No Yes

2.) _____

Smoke No Yes _____ Packs/Day

3.) _____

Alcohol No Occasional Moderate

4.) _____

Drugs (recreational) No Occasional Moderate

Please Turn Page

MEDICAL HISTORY CONTINUED

PATIENT NAME: _____

Health History

Reactions to Anesthesia	<input type="checkbox"/> No <input type="checkbox"/> Yes	AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes	Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lung Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Shortness of Breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hemorrhoids	<input type="checkbox"/> No <input type="checkbox"/> Yes
Poor Vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Seizures/Convulsions	<input type="checkbox"/> No <input type="checkbox"/> Yes	Blood in Stools	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hearing Loss	<input type="checkbox"/> No <input type="checkbox"/> Yes	Alcoholism	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent Urination	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mental Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Burning on Urination	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nosebleeds	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Number of times to Urinate during the night	_____
Sore Throat/Cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gout	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rash	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hoarseness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Liver Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Varicose Veins	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Phlebitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach Ulcers	<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Abnormal Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	Poor Appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last Menstrual Period	_____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chills/Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	_____
Bleeding Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nausea/Vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____
Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes		_____

Please Explain **all** Yes answers _____

Family History

	Living	Deceased	Age at Death	Stroke	High Blood Pressure	Diabetes	Cancer	Type
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
1 Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2 Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3 Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4 Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date of last Chest X-Ray _____ Where Done _____

Date of last Electrocardiogram (EKG) _____ Where Done _____

Notes: _____
