

Patient History Questionnaire-General Surgery

Demographics: please fill out completely

First Name: _____

Middle Name: _____

Last Name: _____

Nickname/ preferred name: _____

Maiden Name: _____

Date of Birth: _____

Gender: **Male** **Female**

Marital Status: **Single** **Married** **Divorced** **Separated** **Partnered** **Widowed**

Social Security Number: - - _____

Ethnicity: **African American** **Arabic** **Asian** **Caucasian** **Hispanic** **Native American** **Other**

Religious Affiliation: _____

Patient Level of Education: _____

Employment Status: **Full-time** **Part-time** **Retired** **Disabled** **Housewife** **Student** **Unemployed**

If disabled, specify the year and the cause: **Year:** _____ **Cause:** _____

Patient Occupation (indicate if student): _____

Patient Employer: _____

Years Employed: _____

Patient Employers Address: _____

Reason for Visit : _____

How did you hear about us? **Internet Chat Rooms** **Magazine** **Newspaper** **Other Patient**

Our Website **Physician** **Television** **Yellow Pages**

Any Specific Questions You Need Addressed? _____

List your preferred procedure: _____

Address Information: please fill out all information completely

Street Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

E-Mail: _____

Phone (home): _____ - _____ - _____ Is it ok to leave a message on this number? Y N

Phone (work): _____ - _____ - _____ Is it ok to leave a message on this number? Y N

Phone (mobile): _____ - _____ - _____ Is it ok to leave a message on this number? Y N

Spouse Information: please fill out all information completely

Spouse name: _____

Spouse employment status: Full-time Part-time Retired Disabled Housewife Student Unemployed

Spouse's occupation (indicate if student): _____

Spouse's SSN: _____ - _____ - _____

Spouse's date of Birth: _____ / _____ / _____

Spouse's Employer: _____

Years Employed: _____

Spouse's Employer Address: _____

Emergency Contact #1:

First Name: _____

Last Name: _____

Relation to you: _____

Phone: _____ - _____ - _____

Primary/ Referring Doctor:

_____ None _____ Physician List _____ Other

Insurance Information: please fill out all information

Insurance Company: _____

Policy Number: _____

Payment Type: _____

Group Number: _____

Full Name of Insured: _____

Effective Date: _____ / _____ / _____

Insured DOB: _____ / _____ / _____

Terminated Date: _____ / _____ / _____

Relationship to Insured: _____

Insured Employer: _____

SS# of Insured: _____ - _____ - _____

Insured ID: _____

Notes: _____

Insurance Phone#: _____ - _____ - _____

Surgical/ Hospitalization History: please circle all surgeries you have ever had in your life time

			Month	Year
Gallbladder (Open):	Y	N	_____	_____
Gallbladder (Laparoscopic)	Y	N	_____	_____
Appendectomy:	Y	N	_____	_____
Hysterectomy (Uterus removed- vaginal):	Y	N	_____	_____
Hysterectomy (Uterus removed- abdominal):	Y	N	_____	_____
Ovary Surgery:	Y	N	_____	_____
Cesarean Section:	Y	N	_____	_____
Back:	Y	N	_____	_____
Right Knee:	Y	N	_____	_____
Left Knee:	Y	N	_____	_____
Right Breast Biopsy:	Y	N	_____	_____
Left Breast Biopsy:	Y	N	_____	_____
Previous Weight-Loss Surgery	Y	N	_____	_____
Tonsillectomy:	Y	N	_____	_____
Hernia:	Y	N	_____	_____
Tubal Ligation:	Y	N	_____	_____
Kidney Transplant:	Y	N	_____	_____
Liver Transplant:	Y	N	_____	_____
Pancreas Transplant:	Y	N	_____	_____
Other 1:	_____	_____	_____	_____
Other 2:	_____	_____	_____	_____
Other 3:	_____	_____	_____	_____

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Review of Systems: Circle all the health problems you have had or are currently experiencing

Cardiovascular:

Heart Attack	Y	N
Angina (chest pain with activity)	Y	N
Rhythm disturbance/ palpitations	Y	N
Congestive Heart Failure	Y	N
High Blood Pressure	Y	N
Ankle Swelling	Y	N
Varicose Veins	Y	N
Hemorrhoids	Y	N
Phlebitis	Y	N
Ankle/ leg ulcers	Y	N
Heart bypass/valve replacement	Y	N
Pacemaker	Y	N
Clogged Heart Arteries	Y	N
Rheumatic fever/ valve damage	Y	N
Heart Murmur	Y	N
Irregular heart beat	Y	N
Cramping in legs when walking	Y	N
Other Symptoms	Y	N

Respiratory:

Asthma	Y	N
Emphysema	Y	N
Bronchitis	Y	N
Pneumonia	Y	N
Chronic Cough	Y	N
Short of Breath	Y	N
Use of CPAP or oxygen supplement	Y	N
Tuberculosis	Y	N
Pulmonary Embolism	Y	N
Hypoventilation Syndrome	Y	N
Cough up blood	Y	N
Snoring	Y	N
Awaken at Night	Y	N
Daytime Drowsiness	Y	N

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Sleep Apnea	Y	N
Lung Surgery	Y	N
Lung Cancer	Y	N

Endocrine:

Hypothyroid (low)	Y	N
Hyperthyroid (high/ overactive)	Y	N
Goiter	Y	N
Parathyroid	Y	N
Elevated Cholesterol	Y	N
Elevated Triglycerides	Y	N
Low Blood Sugar	Y	N
Diabetes (Managed by diet pills)	Y	N
Diabetes (Needing insulin shots)	Y	N
“Prediabetes” with high blood sugar	Y	N
Gout	Y	N
Endocrine gland tumor	Y	N
Cancer of endocrine gland	Y	N
High Calcium level	Y	N
Abnormal facial hair	Y	N

Gastrointestinal:

Heartburn	Y	N
Hiatal Hernia	Y	N
Abdominal Hernia	Y	N
Ulcers	Y	N
Diarrhea	Y	N
Blood in Stool	Y	N
Change in bowel habit	Y	N
Constipation	Y	N
Irritable Bowel	Y	N
Colitis	Y	N
Crohns	Y	N
Hemorrhoids	Y	N
Fissure	Y	N
Rectal Bleeding	Y	N
Black, tarry stool	Y	N

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Polyps	Y	N
Abdominal pain	Y	N
Enlarged Liver	Y	N
Cirrhosis/ hepatitis	Y	N
Gallbladder problems	Y	N
Jaundice	Y	N
Pancreatic disease	Y	N
Unusual vomiting	Y	N
Surgery	Y	N
Cancer	Y	N

Bladder/ Kidney:

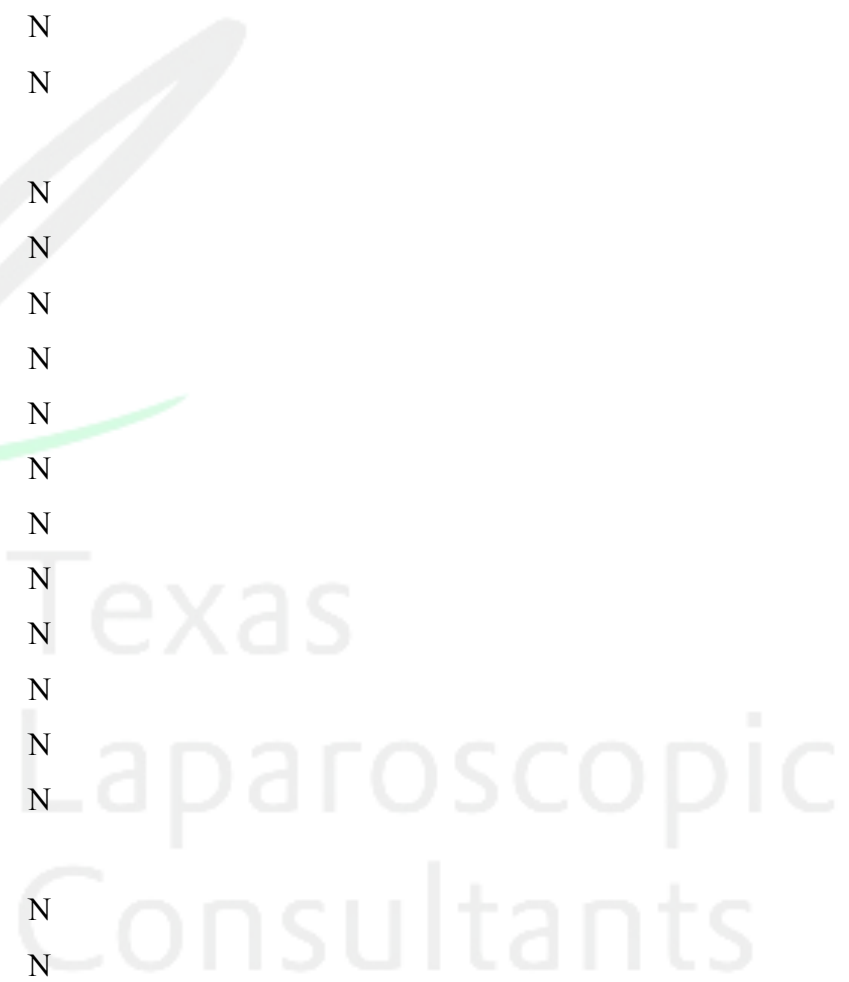
Kidney Stones	Y	N
Blood in Urine	Y	N
Prostate Problems	Y	N
Kidney Failure	Y	N
Leaking Urine	Y	N
For men: PSA in last year?	Y	N
Burning on Urine	Y	N
Loss of bladder control (leakage)	Y	N
Wear panty liner for leakage?	Y	N
Trouble starting urine	Y	N
Surgery	Y	N
Cancer	Y	N

Gynecologic (for women only):

Problems conceiving (infertility)	Y	N
Are you pregnant?	Y	N
Uterine/ Ovarian Cancer	Y	N
Surgery	Y	N
Menstrual irregularity	Y	N
Menstrual pain	Y	N
Excessively heavy periods	Y	N
Do you plan to have more children?	Y	N
Abdominal pain	Y	N

Date of menopause onset _____

Date of last pap smear _____



Date of last Menstrual period _____

Age started menses _____

How many pregnancies have you had? _____

How many children do you have? _____

How many miscarriages or abortions have you had? _____

Musculoskeletal:

Arthritis Y N

Neck Pain Y N

Shoulder Pain Y N

Wrist Pain Y N

Back Pain Y N

Hip Pain Y N

Knee Pain Y N

Ankle Pain Y N

Foot Pain Y N

Heel Pain Y N

Ball of foot/toe pain Y N

Plantar fasciitis Y N

Carpal tunnel syndrome Y N

Lupus Y N

Scleroderma Y N

Sciatica Y N

Autoimmune disease Y N

Muscle pain/spasm Y N

Fibromyalgia Y N

Broken Bones Y N

Joint replacement Y N

Nerve injury Y N

Muscular dystrophy Y N

Surgery Y N

Cancer Y N

Head And Neck:

Wear Contacts/ Glasses Y N

Vision Problems Y N

Hearing Problems Y N

Sinus Drainage	Y	N
Neck Lumps	Y	N
Swallowing Difficulty	Y	N
Dentures/ Partial	Y	N
Oral Sores	Y	N
Hoarseness	Y	N
Head/ Neck Surgery	Y	N
Cancer	Y	N

Neurologic:

Migraine Headaches	Y	N
Balance Disturbance	Y	N
Seizure or Convulsions	Y	N
Weakness	Y	N
Stroke	Y	N
Alzheimer's	Y	N
Pseudotumor cerebri	Y	N
Multiple Sclerosis	Y	N
Frequent severe headaches	Y	N
Knocked Unconscious	Y	N
Surgery	Y	N
Cancer	Y	N

Breast:

Lumps	Y	N
Pain	Y	N
Fibrocystic disease	Y	N
Nipple discharge	Y	N
Surgery	Y	N
Cancer	Y	N

Skin:

Rashes under skin folds	Y	N
Keloids (excessively raised scars)	Y	N
Poor wound healing	Y	N
Frequent skin infections	Y	N
Surgery	Y	N
Cancer	Y	N

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Blood:

Anemia (iron deficient)	Y	N
Anemia (vitamin B12 deficient)	Y	N
HIV	Y	N
Low platelets (thrombocytopenia)	Y	N
Lymphoma	Y	N
Swollen lymph nodes	Y	N
Superficial blood clot in leg	Y	N
Deep blood clot in leg	Y	N
Blood clot in lungs	Y	N
Bleeding disorder	Y	N
Blood transfusion	Y	N
Blood and thinning medicine use	Y	N

Psychiatric:

Anxiety	Y	N
Depression	Y	N
Anorexia	Y	N
Bulimia	Y	N
Bipolar disorder	Y	N
Alcoholism	Y	N
Drug dependency	Y	N
Schizophrenia	Y	N
Other psychiatric problems	Y	N
Hospitalization for psychiatric problems	Y	N
Have you ever been in a psychiatric hospital?	Y	N
Have you ever attempted suicide?	Y	N
Have you ever been physically abused?	Y	N
Have you ever seen a psychiatrist or counselor?	Y	N
Are you currently seeing a psychiatrist or counselor?	Y	N
Have you ever taken medications for psychiatric problems or for depression?	Y	N
Have you ever been in a chemical dependency program?	Y	N

Constitutional:

Fevers	Y	N
Night Sweats	Y	N
Anemia	Y	N
Weight Loss	Y	N
Chronic Fatigue	Y	N
Hair Loss	Y	N

Medications: Please list all medication that you currently use

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Indication</u>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Allergies: please list all allergies

<u>Name of Medication</u>	<u>Reaction it Causes</u>
1.	
2.	
3.	
4.	
5.	

Social history: please fill out all information completely

Tobacco use:

Do you smoke now? Y N

If yes, how many cigarette packs per day? _____

Do you snuff or chew? Y N

If yes, how frequently do you use it? _____

For how many years have you used tobacco? _____ Years

If you have quit, how long ago? _____ Years

Alcohol Use:

Do you consume alcohol now? Y N

If yes, how many times a week? _____

If yes, how many drinks each time? _____

For how many years do/did you drink alcohol? _____ Years

If you have quit, how long ago? _____ Years

Is anyone concerned about the amount you drink? Y N

Drug Use:

Do you use street drugs now? Y N

If yes, which drugs? _____

If yes, how frequently do you use them? _____

If you have quit, how long ago? _____ Years

Caffeine Use:

Do you drink coffee or other caffeine- containing beverages? Y N

If yes, how many cups per day? _____

Do you drink carbonated beverages? Y N

If yes, how many cans per day? _____

Family history: please circle all that apply

Obesity	Y	N
Kidney Disease	Y	N
Heart Disease	Y	N
Diabetes Mellitus	Y	N
High blood pressure	Y	N
Alcoholism	Y	N
Liver problems	Y	N
Lung problems	Y	N
Bleeding disorder	Y	N
Gallstones	Y	N
Mental Illness	Y	N
Cancer	Y	N

Type: _____

If another please specify type: _____

Malignant hyperthermia Y N

Adopted? Y N

of family deaths related to obesity _____

Blood Analysis:

Have you ever received a blood transfusion? Y N

Would you accept a blood transfusion? Y N

Have you ever had hepatitis? Y N

Have you ever been exposed to HIV/ AIDS? Y N

Have you ever abused intravenous drugs? Y N

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