COMMUNITY CARE SURGEONS: HEALTH HISTORY FORM

Date completed: _____

Patient Name:_____ **Date of Birth:**_____ **Primary care provider:**_____

Date of Last Physical Exam:_____ By whom?_____ Present Height:_____ Weight:_____

Please check the appropriate box (Y=YES, N=NO, NS=Not sure) and add information where indicated in the area marked ADDITIONAL INFORMATION/QUESTIONS on the page 2 of this form

Allergy History:	Y	N	NS
Any allergies to medications? **(list on pg 2)**			
Allergy to Latex?			
Other allergies **(list on pg 2)**			

Surgical History:			
Previous surgeries? **(list on pg 2 w/dates)**			
Previous hospitalizations? **(list on pg 2 w/dates)**			
Previous major accidents? **(list on pg 2 w/dates)**			

Additional History:	Y	N	NS
Have you ever taken steroids?			
Have you ever taken diet pills?			
Have you ever been on diet program?			
Have you ever been tested for tuberculosis?			
If yes, re: If yes, results: POS NEG			
Have you ever had cold sores, fever blisters or herpes?			
Have you ever had any serious infections? **(list on pg 2)**			
If child, is he/she up to date with immunizations?			
If less than 15 yo, prematurity?			
Have you seen another doctor for your current problem ?			
Do you live w/someone who can help you after surgery?			
Have you had German measles, mumps or chicken pox?			
Have you had Rheumatic Fever or Scarlet Fever?			

Medical History: Do you have a history of:

Cardiac:	Y	N	NS
High Blood Pressure			
Elevated Cholesterol			
Chest pain			
Previous MI (heart attack)			
Heart Failure			
Other heart problems/illness (i.e. murmur, etc)			
Respiratory:			
Asthma			
Shortness of Breath			
Pneumonia/Bronchitis/Tuberculosis			
Other respiratory problems/illness (i.e. COPD, etc)			
Nervous system/Mental disorders:			
Fainting			
Seizures/Epilepsy			
Strokes/Mini-strokes/TIA's			
Mental illness			
Other brain or nerve problems/illness			
Endocrine:			
Diabetes/High Blood Sugar			
Thyroid disease/goiter			
Hepatic (Liver) or Gallbladder:			
Hepatitis or jaundice			
Gallbladder disease			
Gastrointestinal:			
Irritable Bowel disease or colitis			
Gastroesophageal Reflux (GERD)			
Chronic Heartburn			
Crohn's disease			
Blood in stool			
Other bowel problems/illness			
Males Patients Only:			
Do you have history of prostate enlargement?			
Habit History:			
Do you smoke now? If yes, amount_____ppd			
Have you ever smoked? If yes, year quit_____			
Do you drink alcohol? If yes, amount_____			
Do you use recreational drugs? (i.e. cocaine, marijuana, etc)			

Kidney or Bladder:	Y	N	NS
Kidney Stones			
Blood in urine			
Difficulty urinating			
Other kidney/bladder problems/illness			
Skin/Musculoskeletal:			
Arthritis			
Back pain			
Psoriasis or Eczema			
Problems w/healing			
Problems w/scar formation or keloid scars			
Other skin/musculoskeletal problems			
Hematology:			
Excessive bleeding			
Easy bruising			
Previous blood transfusions? **(list dates on pg 2)**			
Ever tested for sickle cell disease?			
If yes, circle one: No sign of sickle cell Sickle cell trait Unsure			
HEENT: (head, ears, eyes, nose, throat)			
Chronic hoarseness			
Hearing loss			
Do you wear a hearing aid?			
Vision problems/loss			
Do you wear corrective lens?			
Cancer History:			
Have you ever been diagnosed w/cancer?			
If yes, list type/date of diagnosis on page 2			
Gynecological (females only)			
Ever been pregnant?			
Total # of pregnancies_____ # live births_____			
Age at first pregnancy?_____			
Currently pregnant?			
First day of last menstrual period_____(year if postmenopause)			
Have you had PAP in last 3 years?			
Date of last pap_____			
Ever have hysterectomy?			
If so, PARTIAL or TOTAL **(circle one)**			
Do you perform Self Breast Exams?			
Do you have routine mammograms?			
Date of last mammogram?			

COMMUNITY CARE SURGEONS: HEALTH HISTORY FORM (PAGE TWO)

Patient Name:_____ **Date of Birth:**_____

Family History:	Y	N	Age	Medical Problems	If deceased, cause of death
Is your mother living?					
Is your father living?					
Number of Brothers_____ Ages:_____					
Number of Sisters_____ Ages:_____					
Number of Sons_____ Ages:_____					
Number of Daughters_____ Ages:_____					

Medication History: ***Please list dose/frequency of all medications INCLUDING prescription meds, over the counter medications and any vitamins or herbal supplements***

Medication/Vitamin	Dose	Frequency

ADDITIONAL INFORMATION/QUESTIONS: *The information you have provided us with is essential for our comprehensive evaluation of your case. Please feel free to write down any questions you have in the space below so that we may discuss them in detail during our consultation period.*

Allergies:	**Major Accidents:** List with dates
Surgical Hx: List previous surgeries w/dates	**Serious Infections:**
Hospitalizations: List hospital, reason, dates	**Previous blood transfusions:** List dates
Cancer History: List type/date of diagnosis	**Questions:**