

ASSOCIATES IN SURGERY, PA
MEDICAL HISTORY QUESTIONNAIRE

THIS FORM MUST BE COMPLETED BEFORE SEEING THE DOCTOR, PLEASE MARK ALL THAT DO NOT APPLY WITH N/A

NAME _____ AGE _____ SEX _____ APPT. DATE: _____

OCCUPATION _____ REFERRING PHYSICIAN: _____

BRIEFLY DESCRIBE THE REASON FOR SEEING THE DOCTOR TODAY. (IF ACCIDENT INCLUDE NATURE OF ACCIDENT AND WHERE IT OCCURRED) _____

HOW LONG HAS THIS BEEN GOING ON? _____

DATE OF ACCIDENT OR INJURY _____

LIST ANY PREVIOUS SURGERY YOU HAVE HAD.

OPERATION

DATE

LIST ANY MEDICATIONS YOU ARE TAKING.

MEDICATION

DOSE

WHAT MEDICATIONS ARE YOU ALLERGIC TO: _____ LATEX YES NO

IF YOU SMOKE, HOW MANY PACKS PER DAY? _____ IF YOU DRINK ALCOHOL, HOW MANY DRINKS PER WEEK? _____

PLEASE PLACE A CHECK BY ANY MEDICAL ILLNESSES YOU HAVE EVER HAD, LIST ON THE LINES AT THE BOTTOM OF THE PAGE ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE THAT YOU HAVE HAD.

GENERAL: WEIGHT LOSS FEVER

MUSCULOSKELETAL: SPINAL CORD INJURY
 ARTHRITIS

EYES: WEARS GLASSES/CONTACTS GLAUCOMA

SKIN: JAUNDICE OPEN WOUNDS

ENT: SINUSITIS CHRONIC RHINITIS

NEUROLOGICAL: STROKE PARALYSIS R L

CARDIOVASCULAR: LEG SWELLING VARICOSE VEIN
 CALF PAIN WHEN WALKING FOOT PAIN AT REST
 CHEST PAIN HYPERTENSION HEART ATTACK
 SHORTNESS OF BREATH IRREGULAR HEART RATE

PSYCHIATRIC: DEPRESSION MEMORY LOSS

ENDOCRINE: DIABETES THYROID DYSFUNCTION

RESPIRATORY: PNEUMONIA TUBERCULOSIS
 ASTHMA LUNG CANCER COUGHING BLOOD

HEMATOLOGIC/LYMPHATIC: SWOLLEN GLANDS
 ANEMIA BLEEDING DISORDERS

GASTROINTESTINAL: NAUSEA DIARRHEA
 HEMORRHOIDS BLOOD IN STOOL INDIGESTION
 ABDOMINAL PAIN HEPATITIS

ALLERGY/IMMUNOLOGIC: HAYFEVER

URINARY: PROSTATE TROUBLE KIDNEY STONES
 BLOOD IN URINE BURNING WITH URINATION

FEMALES: LAST MENSTRUAL PERIOD _____

PERSONAL HISTORY OF CANCER: _____

FAMILY HISTORY OF CANCER: _____

OTHER MEDICAL PROBLEMS: _____

NURSE REVIEW _____

PHYSICIAN REVIEW _____

