



Patient Health History

Reviewed By: _____

Name: _____ Birth Date: _____ Today's Date: _____

Briefly explain why you are seeing the surgeon today: _____

PAST SURGICAL HISTORY:

(Please check all that apply to past surgical history.)

| | <i>Yes</i> | <i>Dates/Detail</i> |
|---|------------|---------------------|
| <u>EYES, EARS, NOSE, THROAT & MOUTH</u> | | |
| Cataract or Other Eye Surgery | _____ | _____ |
| Ears, Nose, Throat Surgery (please circle T&A, ear tubes, thyroid)..... | _____ | _____ |
| <u>CARDIOVASCULAR</u> | | |
| Abdominal Aortic Aneurysm Resection with Graft Placement | _____ | _____ |
| Angioplasty/Stent Placement | _____ | _____ |
| Carotid Endarterectomy | _____ | _____ |
| Coronary Artery Bypass (please list # of vessels)..... | _____ | _____ |
| Extremity Artery Bypass with Graft or Angioplasty (please list location) | _____ | _____ |
| Heart Catheterization | _____ | _____ |
| Heart Valve Replacement (please list which valve)..... | _____ | _____ |
| <u>GASTROINTESTINAL</u> | | |
| Appendix Surgery | _____ | _____ |
| Colon Surgery | _____ | _____ |
| Gallbladder Surgery (please circle either open or laparoscopic)..... | _____ | _____ |
| Sigmoidoscopy - "short scope" | _____ | _____ |
| Stomach (EGD, gastroscopy)..... | _____ | _____ |
| Total Colon (colonoscopy – "long scope with sedation")..... | _____ | _____ |
| <u>GENITOURINARY</u> | | |
| Bladder Surgery (please describe) | _____ | _____ |
| Cystoscopy (scope test looking into bladder)..... | _____ | _____ |
| Kidney Stone Surgery (please circle open or lithotripsy) | _____ | _____ |
| <u>WOMEN</u> | | |
| Cesarean Section (how many?)..... | _____ | _____ |
| D&C..... | _____ | _____ |
| Hysterectomy (please circle Abdominal or Vaginal) | _____ | _____ |
| Ovaries Removed | _____ | _____ |
| Sterilization (tubal ligation) | _____ | _____ |
| <u>MEN</u> | | |
| Prostate Surgery (please circle TURP, prostatectomy) | _____ | _____ |
| Sterilization (vasectomy) | _____ | _____ |
| <u>INTEGUMENTARY/BREAST</u> | | |
| Breast Surgery (please circle Right or Left / Biopsy or Mastectomy) | _____ | _____ |
| Hernia Surgery | _____ | _____ |
| <u>MUSCULOSKELETAL</u> | | |
| Orthopedic Surgery/Joint Replacement (please list joint)..... | _____ | _____ |
| Arthroscopy (please list location) | _____ | _____ |
| Back or Spinal Surgery | _____ | _____ |
| Bone Fracture/Repair (please list location)..... | _____ | _____ |
| <u>SKIN & SOFT TISSUE</u> | | |
| Plastic Reconstructive Surgery (please list location) | _____ | _____ |

Other Surgery: _____

PAST ANESTHESIA HISTORY:

| | <i>Yes</i> | <i>Dates/Detail</i> |
|--|------------|---------------------|
| Have you or a family member had serious problems with anesthesia? | _____ | _____ |
| Please explain: _____ | | |
| Fevers with Anesthetic? | _____ | _____ |
| Have you ever had a blood transfusion? | _____ | _____ |
| Allergy to Latex? | _____ | _____ |
| (If yes, please fill out latex allergy questionnaire) | | |

PAST MEDICAL HISTORY (check all that apply to patient’s history):

RESPIRATORY

Asthma _____

Chronic obstructive pulmonary disease (COPD) _____

 Bronchitis _____

 Emphysema _____

CARDIOVASCULAR

Angina, Coronary artery disease _____

Atrial fibrillation (A. fib) _____

Congestive heart failure (CHF) _____

Heart attack (myocardial infarction) _____

High blood pressure (hypertension) _____

High cholesterol or triglycerides (dyslipidemia) _____

Pacemaker/Implantable defibrillator _____

Valvular heart disease/murmur _____

GASTROINTESTINAL

Colon polyps _____

Diverticulosis/Diverticulitis _____

Gallstones or gallbladder disease _____

Gastroesophageal reflux disease (GERD) _____

Hemorrhoids _____

Hepatitis A, B, C (circle type please) _____

Hiatal hernia _____

HIV positive _____

Inflammatory bowel disease _____

 Crohn’s disease _____

 Ulcerative colitis _____

Liver disease _____

Pancreatitis _____

Stomach or duodenal ulcers _____

TB or positive skin test _____

GENITOURINARY

Benign prostatic enlargement (BPH) _____

Kidney stones _____

ENDOCRINE

Diabetes mellitus _____

Osteoporosis/osteopenia _____

Over-active thyroid (hyperthyroidism) _____

Thyroid enlargement/goiter/nodule/cyst _____

 (please circle all that apply)

Under-active thyroid (hypothyroidism) _____

NEUROLOGICAL

Arthritis (please circle below) _____

 a) Rheumatoid

 b) Osteoarthritis

 c) Gout

Migraine headaches _____

Parkinson’s disease _____

Seizure disorder _____

Stroke (CVA) _____

TIA (transient ischemic attack) _____

HEMATOLOGIC

Anemia _____

Blood clot in lung (PE) _____

Deep vein thrombosis (DVT) _____

Other medical conditions, hospitalizations, accidents, illnesses, injuries, pregnancy problems, etc. (please explain):

| FAMILY MEDICAL HISTORY | | | | | | |
|-------------------------------------|----------------------|----------------------|-------------------------------|------------------------------|-------------------------------|----------|
| | Father Age: _____ | Mother Age: _____ | Brothers Total #: _____ | Sisters Total #: _____ | Children Total #: _____ | Comments |
| # Living | | | | | | |
| # Deceased | | | | | | |
| Cause of Death (if applies) | | | | | | |
| Please check all that apply: | | | | | | |
| Breast Cancer | | | | | | |
| Colon Cancer | | | | | | |
| Other Cancer (list type) | | | | | | |
| Diabetes Mellitus | | | | | | |
| High Blood Pressure | | | | | | |
| Heart Attack/ Disease | | | | | | |
| Other (please list) | | | | | | |

Additional Family History (i.e., grandparents, aunts, uncles): _____
