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| **All questions contained in this questionnaire are strictly confidential and will become part of your medical record.** |
| Name |  | [ ]  M [ ]  F | Date |
| Phone |  |  | **DOB** |
| Purpose of Surgery |  | Location & Date of Surgery |  | **Surgeon** |  |
|  |
| childhood HEALTH HISTORY |
| Childhood Illness: | [ ]  Measles [ ]  Mumps [ ]  Rubella [ ]  Chickenpox [ ]  Rheumatic Fever [ ]  Polio |
| Immunizations and dates: | [ ]  Tetanus | [ ]  Pneumonia |
| [ ]  Hepatitis A: B: | [ ]  Chickenpox |
| [ ]  Influenza | [ ]  MMR Measles, Mumps, Rubella |
| PAST MEDICAL HISTORY |
| Please indicate if you have ever had any of the following medical conditions. Check if YES and circle the appropriate condition. |
| [ ]  Anemia/Bleeding Disorders/Blood Diseases | [ ]  Knee Problems | [ ]  Alcoholism/Drug Addiction |
| [ ]  Asthma/Emphysema/Chronic Bronchitis/  Asbestos/Silicosis/Tuberculosis /Pneumothorax/ Lung Cancer/Pneumonia/Other | [ ]  High Blood Pressure/Heart Disease/Heart  Murmur/Heart Attack/Stroke/Angina/Heart  Failure/Swelling in Feet/Legs | [ ]  Numbness/Tingling Pain in  Wrists/Hands/Arms |
| [ ]  Breathing Difficulties/Chronic Cough | [ ]  Deafness/Hearing Loss/Ear Problems | [ ]  Sinus Problems/Hay Fever |
| [ ]  Loss of Consciousness/Seizures/Convulsions | [ ]  Cancer/Tumor/Leukemia | [ ]  Problems smelling odors |
| [ ]  Hepatitis/Liver Disease/Gallstones | [ ]  Arthritis/Rheumatism | [ ]  Allergy that interferes with breathing |
| [ ]  Kidney Disease/Kidney Stones | [ ]  Color Blindness/Vision Problems | [ ]  Skin Allergy or sensitivity |
| [ ]  Sexually Transmitted Disease | [ ]  Claustrophobia | [ ]  Joint Problems |
| [ ]  Diabetes/Sugar Disorders | [ ]  Digestive Problems/Ulcer/Bowel Disease | [ ]  Hospitalization for any reason  |
| [ ]  Neck/Back Problems | [ ]  Psychiatric/Emotional Problems | [ ]  None of the listed has occurred |
| [ ]  Allergy to Medications, please list: | [ ]  Other Medical Problems not listed: |
|  |  |
|  |  |
| **Please indicate if you have ever had any of the following operations or injuries. Check if YES.** |
| [ ]  Splenectomy (Removal of Spleen) | [ ]  Colon/Rectal/Bowel Surgery | [ ]  Hernia Repair |
| [ ]  Ulcer/Stomach Surgery | [ ]  Hysterectomy/Removal of Ovaries | [ ]  Thyroid Surgery |
| [ ]  Neck/Chest/Back/Knee Surgery | [ ]  Vasectomy/Tubal Ligation | [ ]  Gallbladder Surgery |
| [ ]  Other surgery or injury, including auto accidents,  chest, and work-related injuries. Please list: | [ ]  Any Broken Bones/Ribs | [ ]  None of the listed has occurred |
|  |
| 75BHEALTH HABITS |
| 76BExercise | [ ]  Sedentary (No exercise) [ ]  Mild Exercise (i.e., climb stairs, walk 3 blocks) [ ]  Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes) [ ]  Regular vigorous exercise (i.e., work or recreation, more than 4x/week for 30 minutes)  |
| 81Caffeine | [ ]  None [ ]  Coffee [ ]  Tea [ ]  Cola # of cups/cans per day?  |
|  | 75HEALTH HABITS Continued  |
| 8BAlcohol | 84BDo you drink alcohol? [ ]  Yes [ ]  No If yes, what kind? How many drinks per week? |
| Have you ever experienced blackouts? [ ]  Yes [ ]  No Are you prone to “binge” drinking? [ ]  Yes [ ]  No |
| Tobacco | 86BDo you use tobacco? [ ]  Yes [ ]  No [ ]  Cigarettes-pks./day [ ]  Chew-#/day [ ]  Pipe-#/day [ ]  Cigars-#/day |
| 87B# of years smoking? Or the year that you quit |
| 8Drugs | 89BDo you currently use recreational or street drugs? [ ]  Yes [ ]  No |
|  |  |  |  |  |
| **REVIEW OF SYMPTOMS** |
| **During the past year, have you had any of the following symptoms?** |
| **Neurological/Psychological** | **Pulmonary** | **Genitourinary** |
| [ ]  Frequent of Severe Headaches | [ ]  Shortness of Breath – At Rest | [ ]  Usually get up more than once a night to Urinate |
| [ ]  Difficulty Sleeping | [ ]  Shortness of Breath – Exertion | [ ]  Urinary Infection or Discharge, Bloody Urine, or Kidney Stone |
| [ ]  Unsteadiness in Balance, Dizzy Spells | [ ]  Wheezing in the Chest | [ ]  Discomfort when Urinating |
| [ ]  Difficulty with Concentration or Memory | [ ]  Persistent Hoarseness |  |
| [ ]  A Tremor | [ ]  Persistent/Unusual Cough | **Women Only** |
| [ ]  Problems with Nervousness | [ ]  Productive | [ ]  Vaginal Bleeding other than at the time of your period |
| [ ]  Depression or Feeling Down | [ ]  Nonproductive | [ ]  Currently have Painful Menstrual Periods |
| [ ]  Paralysis in part of your body | [ ]  Bloody Sputum | [ ]  Menstrual Periods have ceased |
| [ ]  A Seizure or Convulsion |  | [ ]  Perform breast exams monthly |
| [ ]  Unusual Stress in your Work Life | **Musculoskeletal** | [ ]  You had Breast Surgery |
| [ ]  Unusual Stress in your Home Life | [ ]  Joint Pain or Arthritis | [ ]  Lumps in breast now |
|  | [ ]  Difficulty with Back or Neck | [ ]  Have ever had discharge or bleeding from nipples |
| **Gastrointestinal** | [ ]  Muscle Weakness | [ ]  Infertility |
| [ ]  Difficulty Swallowing | [ ]  Excessive Fatigue | Date of last Menstrual Cycle: |
| [ ]  Abdominal Pain or Chronic Indigestion |  | Date of last Pap Smear: |
| [ ]  A Change in Bowel Habits | **Cardiovascular** | Pap Smear Results: |
| [ ]  Persistent Diarrhea | [ ]  Chest Pain/Tightness or Discomfort |  |
| [ ]  Black Tar-Like or Bloody Bowel Movements | [ ]  At Rest [ ]  With Exertion | **Men Only** |
| [ ]  Repeated Vomiting | [ ]  Heart Palpitations or Skipped Beats | [ ]  Prostate Infection |
|  | [ ]  Swelling of your Ankles/Feet | [ ]  Enlarged Prostate |
| **Head, Eyes, Ears, Nose and Throat** | [ ]  Leg Cramps with Walking | [ ]  Cyst or Tumor of the Testicles |
| [ ]  Sinus Problems other than Colds | [ ]  Heartburn/Indigestion not related to eating | [ ]  Prostate Surgery |
| [ ]  Hay Fever, Hives, or Asthma | [ ]  Difficulty climbing stairs/ladders with 25+ lbs. | [ ]  Cancer of the Prostate |
| [ ]  Difficulty with your Eyes or Vision |  | [ ]  Infertility |
| [ ]  Difficulty with Ears/Hearing Aid | **Endocrine** | If yes, give details: |
| [ ]  Problems with smelling odors | [ ]  Weight Loss or Gain of more than 10 lbs. |  |
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| **Dermatologic** | **Hematologic** |  |
| [ ]  Skin Problems | [ ]  Unusual Bleeding |  |
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| Please list all current medications: |
|  |
| Please list any medical conditions that have not been addressed in this questionnaire: |
|  |
| I certify that I have reviewed the foregoing information supplied by me and that it is true and correct to the best of my knowledge. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Patient Printed Name |  | Patient Signature |  |  | Date |