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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: | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | | | | |
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| **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 | | | | | | |  | | | | | | | |
|  | | | |  | | | | | | |  | | | | | | | |
| Please list all current medications: | | | | | | | | | | | | | | | | | | |
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| Please list any medical conditions that have not been addressed in this questionnaire: | | | | | | | | | | | | | | | | | | |
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| 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. | | | | | | | | | | | | | | | | | | |
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| Patient Printed Name | | | | | | |  | Patient Signature | | | | | | |  |  | | Date |