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## Health History Questionnaire

The following questions are designed to give your surgeon important health information about you. Please answer them as accurately and completely as possible. All information is strictly confidential.

Name \_\_\_\_\_ Date \_\_\_\_\_

- Who is your primary care physician? \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

- Which physician referred you to this office? \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

- Do you have any allergies?  No  Yes If yes, please list and briefly describe any reactions.

(Be sure to include allergies to medication, food, environment, etc.)

\_\_\_\_\_  
 \_\_\_\_\_

- Have you or any blood relative ever had reaction to blood or blood product transfusions?

No  Yes If yes, please describe:

\_\_\_\_\_

- Have you or any blood relative ever had reaction to anesthesia  No  Yes If yes, please describe:

\_\_\_\_\_

- Do you smoke?  No  Yes If yes, how many packs per day? \_\_\_\_\_

Are you a former smoker?  No  Yes If yes, how long ago did you quit? \_\_\_\_\_

Do you use smokeless tobacco?  Yes  No

Do you use nicotine patches or gum?  Yes  No

- Do you drink alcohol?  No  Yes If yes:  rarely  moderately  daily

- Have you ever had surgery or been hospitalized?  Yes  No

If yes, please list the surgery or condition, year, hospital and physician.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Please list all medications that you take.

(Be sure to include vitamins, herbs, birth control pills,, aspirin, and over the counter medications.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please also fill out the second page**

**Surgery Health History Questionnaire** (continued)

• Please check any of the following conditions that you have or have had:

- |   |  |
|---|--|
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Hepatitis                 |
| <input type="checkbox"/> Angina or chest pain           | <input type="checkbox"/> Hernia                    |
| <input type="checkbox"/> Anxiety or nervousness         | <input type="checkbox"/> High blood pressure       |
| <input type="checkbox"/> Asthma or wheezing             | <input type="checkbox"/> Irregular heart beat      |
| <input type="checkbox"/> Autoimmune problems            | <input type="checkbox"/> Jaundice                  |
| <input type="checkbox"/> Back pain                      | <input type="checkbox"/> Kidney problems           |
| <input type="checkbox"/> Bleeding problems              | <input type="checkbox"/> Migraine headaches        |
| <input type="checkbox"/> Blood in urine or stool        | <input type="checkbox"/> Mitral valve prolapse     |
| <input type="checkbox"/> Bronchitis                     | <input type="checkbox"/> Paralysis                 |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Polio                     |
| <input type="checkbox"/> Change in bowel habits         | <input type="checkbox"/> Rheumatic fever           |
| <input type="checkbox"/> Diabetes (sugar)               | <input type="checkbox"/> Seizures or Epilepsy      |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Shortness of breath       |
| <input type="checkbox"/> Dizziness or vertigo           | <input type="checkbox"/> Skin problems             |
| <input type="checkbox"/> Drug and/or alcohol dependency | <input type="checkbox"/> Stool incontinence        |
| <input type="checkbox"/> Edema (swelling)               | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Emphysema / COPD               | <input type="checkbox"/> Syncope (fainting spells) |
| <input type="checkbox"/> Heart disease / Angina         | <input type="checkbox"/> Thyroid problems          |
| <input type="checkbox"/> Heart attacks                  | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Heart murmur                   | <input type="checkbox"/> Urine incontinence        |
| <input type="checkbox"/> Hemorrhoids                    |  |

• Are there any other medical conditions not listed above that you have or have had? Please list:

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• **Female patients only:**

Have you ever had a mammogram?  No  Yes

If yes, when was your most recent mammogram? \_\_\_\_\_

Do you menstruate (have a period)?  No  Yes

If yes, when was the first day of your last menstrual period? \_\_\_\_\_

Signature of patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of physician \_\_\_\_\_ Date: \_\_\_\_\_