GENERAL SURGERY ASSOCIATES
PATIENT HEALTH HISTORY

Patient Name _____ Date of Birth _____

Please list **ALL** medications you are currently taking and dosage, including non-prescription drugs (ex, vitamins, supplements, OTC remedies)

Medication	Dosage	Medication	Dosage
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Do you take Aspirin, Advil, Ibuprofen, Aleve, or Naprosyn regularly? YES NO

SURGERY/ OPERATIONS	DATE	SURGERY/ OPERATIONS	DATE
1. _____	___/___/___	3._____	___/___/___
2. _____	___/___/___	4. _____	___/___/___

ALLERGIES
Please list any allergies to any food or medications
_____ _____ _____ _____

Do you smoke (cigarettes/cigars/marijuana)? YES NO # per day _____ Date started _____ Quit _____

Do you have any blood relatives who have had any of the following: PLEASE CIRCLE
CANCER HEART ATTACK DIABETES STROKE TUBERCULOSIS HIGH BLOOD PRESSURE

PERSONAL HISTORY
Circle all that apply
Tuberculosis Heart Disease Diabetes Cancer High Blood Pressure Heart Disease
Pneumonia COPD Asthma Gallbladder Disease Jaundice Hepatitis or HIV Anemia
Colitis or other bowel disease Hemorrhoids or any rectal disease Nephritis (kidney disease)
Bladder disease Any bones or joint disease Polio or Meningitits Any other disease

REVIEW OF SYMPTOMS Please indicate any **personal** history below PLEASE CIRCLE

ENDOCRINE
Glandular or hormone problem
Excessive thirst or urination
Heat or Cold Tolerance
Skin becoming dryer
Change in hat or glove size

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing
Earaches or drainage
Chronic sinus problems or rhinitis
Nose bleeds
Mouth Sores
Bleeding Gums
Sore throat or voice change
Swollen glands in neck

EXTREMETIES
Blue toes or fingers
Blood clots or phlebitis
Varicose veins
Pain in calves/thigh/buttocks when walking

SKIN
Non healing wound or injury
Mole changing or enlarging
Rash or Itching
Change in Skin Color
Change in hair or nails

EYES
Blurred or double vision
Wear glasses/contacts lenses

BREAST
Breast pain
Breast lump
Family history of breast Cancer
Take Birth control pills
Surgery on breast
Recent Mammogram
Breast discharge

MUSCOLOSKELETAL
Joint Pain
Joint Stiffness or Swelling
Weakness or muscle cramps
Back Pain

GASTROINTESTINAL
Rectal bleeding or blood in stool
Loss of appetite
Change in Bowel movements
Nausea or Vomiting
Frequent diarrhea
Painful bowel movements or constipation

GENITOURINARY
Frequent Urination
Burning or painful urination
Blood in urine
Incontinence or dribbling
Kidney stones

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Blood transfusion in the past
Enlarged glands

NEUROLOGICAL
Frequent or recurrent headaches
convulsions or seizures
Light headed or dizzy
Numbness or ringing sensations
Tremors
Paralysis
Head Injury

CONSTITUTIONAL SYMPTOMS
Good general health
Recent weight change

PSYCHIATRIC
Memory loss or confusion
Depression
Insomnia
Nervousness

CARDIOVASCULAR
Heart Trouble
Chest pain or angina pectoris
Palpitation
Shortness of Breath
Wheezing