

# EVANSVILLE SURGICAL ASSOCIATES

## MEDICAL HISTORY FORM

FOR OFFICE USE ONLY:  NEW PATIENT  ESTABLISHED PATIENT

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ B/P(R) \_\_\_\_\_ (L) \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

**To Be Completed by Patient (please print):**

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
Last First

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

### CHIEF COMPLAINT:

Why are you here today? \_\_\_\_\_ How long have you had this problem? \_\_\_\_\_

### PAST MEDICAL HISTORY: Other than checked, all other symptoms negative

**Do you have or have you ever been treated for any of the following?**

- |   |  |  |
|---|--|--|
| Y N   | Y N  | Y N  |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> HIV                    | <input type="checkbox"/> <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis           | <input type="checkbox"/> <input type="checkbox"/> Thyroid                | <input type="checkbox"/> <input type="checkbox"/> Cancer (where _____)     |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes            | <input type="checkbox"/> <input type="checkbox"/> Seizures               | COLON  |
| <input type="checkbox"/> <input type="checkbox"/> Bladder             | <input type="checkbox"/> <input type="checkbox"/> Transfusion with blood | <input type="checkbox"/> <input type="checkbox"/> Diverticulitis           |
| <input type="checkbox"/> <input type="checkbox"/> Migraines           | by-products  | <input type="checkbox"/> <input type="checkbox"/> Colon polyps             |
| <input type="checkbox"/> <input type="checkbox"/> Ulcer               | LUNG   | <input type="checkbox"/> <input type="checkbox"/> Colon cancer             |
| HEART   | <input type="checkbox"/> <input type="checkbox"/> COPD                   | <input type="checkbox"/> <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> <input type="checkbox"/> Liver Problems           |
| <input type="checkbox"/> <input type="checkbox"/> Atrial Fib          | <input type="checkbox"/> <input type="checkbox"/> Asthma                 | <input type="checkbox"/> <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> <input type="checkbox"/> Other _____         | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> <input type="checkbox"/> Injury _____             |

Cardiologist Name \_\_\_\_\_ Pulmonologist Name \_\_\_\_\_

Kidney Disease \_\_\_\_\_ Nephrologist Name \_\_\_\_\_

Dialysis When/Where \_\_\_\_\_

### SURGICAL HISTORY:

	When		When
Circulation/Arterial/Venous	_____	Hernia	_____
Hysterectomy/Tubes/Ovaries	_____	Appendix	_____
Colectomy	_____	Gallbladder	_____
Heart/Lung	_____	Thyroid	_____
Breast	_____	Other	_____

### SOCIAL HISTORY:

Do you smoke? yes \_\_\_\_\_ no \_\_\_\_\_ Have you ever smoked yes \_\_\_\_\_ no \_\_\_\_\_  
How Much? \_\_\_\_\_ How Long? \_\_\_\_\_  
Do you use alcohol? yes \_\_\_\_\_ no \_\_\_\_\_  
Amount per day \_\_\_\_\_  
Occupation \_\_\_\_\_

**MEDICAL HISTORY INFORMATION CONTINUED ON BACK OF THIS FORM**

PATIENT NAME: \_\_\_\_\_

**FAMILY HISTORY:**

	<b>Family Member</b>	<b>Have you had any of the following tests?</b>	<b>When / Where</b>
Heart Disease	_____	Blood tests	_____
High blood pressure	_____	EKG	_____
Diabetes	_____	X-rays	_____
Cancer	_____	Ultrasound	_____
Gallbladder disease	_____	CAT scan	_____
Stroke	_____	Upper Endoscopy	_____
Thyroid disease	_____	Colonoscopy	_____
Other	_____	Mammogram	_____
Lung disease	_____	Other	_____
Problems with anesthesia	_____		

**REVIEW OF SYSTEMS:**

**CHECK ANY SYMPTOMS THAT YOU HAVE NOW:**     Other than checked, all other symptoms negative

<p><b>CONSTITUTIONAL</b></p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Soaking sweats <input type="checkbox"/> Unaccountable weight loss <input type="checkbox"/> Appetite change	<p><b>BLOOD/LYMPHATIC</b></p> <input type="checkbox"/> Bleeding <input type="checkbox"/> Unusual bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Other	<p><b>EARS,EYES, NOSE, THROAT</b></p> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Vision loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Other	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Heart attack <input type="checkbox"/> Chest pain (angina) <input type="checkbox"/> Irregular heart beat (arrhythmias or palpitations) <input type="checkbox"/> Swelling of feet <input type="checkbox"/> Coldness of hands or feet <input type="checkbox"/> Other	<p><b>RESPIRATORY</b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Short of breath (dyspnea) <input type="checkbox"/> Blood in sputum <input type="checkbox"/> Awaken choking <input type="checkbox"/> Awaken short of breath <input type="checkbox"/> Other
<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Stomach pain <input type="checkbox"/> Spastic colon <input type="checkbox"/> Colon cancer <input type="checkbox"/> Change in bowels <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Blood in stools (hematochezia) <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Other	<p><b>GENITOURINARY/ GYNECOLOGIC</b></p> <input type="checkbox"/> Burning with urine <input type="checkbox"/> Difficulty starting stream <input type="checkbox"/> Kidney stones <input type="checkbox"/> Bladder infections <input type="checkbox"/> Date of last menstrual period <input type="checkbox"/> Are you or could you be pregnant? <input type="checkbox"/> Other	<p><b>BREAST</b></p> <input type="checkbox"/> Cancer <input type="checkbox"/> Breast pain <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Breast mass <input type="checkbox"/> Other	<p><b>SKIN</b></p> <input type="checkbox"/> Cancer <input type="checkbox"/> Other	<p><b>NEUROLOGICAL</b></p> <input type="checkbox"/> Stroke <input type="checkbox"/> Dizziness (vertigo) <input type="checkbox"/> Arm or leg weakness <input type="checkbox"/> Fainting spells (syncope) <input type="checkbox"/> Headaches <input type="checkbox"/> Other

<p><b>Form completed by:</b> _____ <b>Date:</b> _____ <b>Reviewed by MD:</b> _____</p>
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