EVANSVILLE SURGICAL ASSOCIATES

Patient Health History

Patient Name: _____ DOB: _____ Date: _____ ☐M ☐F

Reason for Visit:	How long have you had this problem?

Physicians

Referring Physician Name	City	State	Phone
Family Physician Name	City	State	Phone
Other Physician Name	City	State	Phone

Medications: Please include aspirin, all prescriptions, non-prescription, and herbal supplements

Medication	Dosage	How often?	Medication	Dosage	How often?

Allergies: Please list all medications you are allergic to and your reaction

Medication	Reaction	Medication	Reaction

Medical History: Have you ever had any of the following?

Y N		Y N		Y N		Y N	
☐ ☐	Hypertension	☐ ☐	Liver Disorder	☐ ☐	Diverticulitis of Colon	☐ ☐	Thyroid Disease
☐ ☐	High Cholesterol	☐ ☐	Seizure Disorder	☐ ☐	Colon Polyps	☐ ☐	Asthma
☐ ☐	High Lipids	☐ ☐	Blood Disorder _____	☐ ☐	IBS	☐ ☐	Sleep Apnea
☐ ☐	Arthritis	☐ ☐	Hepatitis _____	☐ ☐	Heart Attack	☐ ☐	Tuberculosis
☐ ☐	Diabetes	☐ ☐	Cancer _____	☐ ☐	Atrial Fibrillation	☐ ☐	Stroke
☐ ☐	Stomach Ulcer	☐ ☐	Urinary Incontinence	☐ ☐	Renal Failure	☐ ☐	Autoimmune Disease
☐ ☐	Heartburn	☐ ☐	Urinary Tract Infection	Dialysis Unit _____		☐ ☐	Other Past Medical History
☐ ☐	Migraine	☐ ☐	Benign Prostatic Hyperplasia	☐ ☐	COPD	_____	
☐ ☐	Physical Trauma _____			☐ ☐	Pneumonia		

Surgical History: Please provide the year you had the procedure on the line. ☐ No surgical history

Y		Y		Y		Y		Y	
☐	Open Heart _____	☐	Colostomy _____	☐	Spleen _____	☐	Lung _____	☐	Ovary Removed _____
☐	Cardiac Cath _____	☐	Gallbladder _____	☐	Kidney _____	☐	Pilonidal Cyst _____	☐	Prostate _____
☐	Pacemaker _____	☐	Hernia Repair _____	☐	Back _____	☐	Parathyroid _____	☐	Brain _____
☐	Defibrillator _____	☐	Colon Removed _____	☐	Carpel Tunnel _____	☐	Thyroid _____	☐	AAA repair _____
☐	Cardiac Stent _____	☐	Hemorrhoid _____	☐	Hip Replaced _____	☐	Breast _____	☐	Foot Removed _____
☐	Heart Valve _____	☐	Ileostomy _____	☐	Knee Replaced _____	☐	Cesarean Section _____	☐	Leg Removed _____
☐	Appendix _____	☐	Nissen Fund _____	☐	Rotator Cuff _____	☐	Hysterectomy _____	☐	Carotid _____
☐	EVLT _____	☐	Arm Fistula _____	☐	Arm Graft _____	☐	Leg Bypass _____	☐	Varicose Vein _____
☐	Stent Placement (Non-cardiac) _____			☐	Sleeve Gastrectomy _____	☐	Gastric Band _____	☐	Gastric Bypass _____
☐	Other surgeries _____								

EVANSVILLE SURGICAL ASSOCIATES

Patient Health History

Social History

Do you smoke? ☐ Yes ☐ No If no, have you ever? ☐ Yes ☐ No If yes, how long ago did you quit? _____
If yes, how much? _____ For how many years? _____

Do you use chewing nicotine- containing substances? ☐ Yes ☐ No **Do you use recreational drugs?** ☐ Yes ☐ No

Do you drink beer/wine/alcohol? ☐ Yes ☐ Occasional ☐ Frequently How much? _____
☐ No ☐ Never ☐ Previously, but quit. How long ago? _____

Family History

	Health Problems
Mother	
Maternal Grandmother	
Maternal Grandfather	
Father	
Paternal Grandmother	
Paternal Grandfather	
Brother(s)	
Sister(s)	
Son/Daughter	

☐ Adopted ☐ No Family History

Do you currently have any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Weight loss	☐	☐	Swollen lymph nodes in groin	☐	☐	Cough	☐	☐	Constipation
☐	☐	Fever	☐	☐	Swollen lymph nodes in neck	☐	☐	Difficulty breathing	☐	☐	Bright red blood from rectum
☐	☐	Chills	☐	☐	Dizziness	☐	☐	Abdominal pain	☐	☐	Swelling of feet
☐	☐	Hoarseness	☐	☐	Fainting	☐	☐	Trouble swallowing	☐	☐	Headache
☐	☐	Sore throat	☐	☐	Limb weakness	☐	☐	Nausea	☐	☐	Anxiety
☐	☐	Blood in urine	☐	☐	Chest pain	☐	☐	Vomiting	☐	☐	Depression
☐	☐	Pain Urinating	☐	☐	Fast heart rate	☐	☐	Black or tarry stools			
☐	☐	Rash	☐	☐	Cold hands or feet	☐	☐	Diarrhea			

Screening History

All patients ages 45-75 When was your last colonoscopy? _____
Female patients over the age of 40 When was your last mammogram? _____

Evansville Surgical Associates' physicians recommend you have a screening colonoscopy every 10 years unless otherwise indicated by a family doctor or specialist. They also recommend females have a yearly screening mammogram.

Patient Signature: _____ Date: _____