Surgical Specialists of St. Joseph, P.C.
PATIENT HISTORY FORM

Name: **Date:**

Date of Birth: **Age:** **Phone #:** **Family Doctor:**

Current Problem?

Past Medical Problems:
1. ______
2. ______
3. ______
4. ______

Past Surgeries:
1. ______
2. ______
3. ______
4. ______

Allergies: ☐ **None**
1. ______
2. ______
3. ______
4. ______

Medications: *(Include nonprescription drugs, Vitamins, and Herbal drugs)*
1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______

Social History:

	Y	N
Do you smoke?	☐	☐
Have you smoked in the past?	☐	☐
Do you drink alcohol?	☐	☐
Are you employed?	☐	☐

What is your Job?
Your Employer?
Marital Status: ☐ Single
▷ Married
▷ Divorced
▷ Widowed

Family History:

	Y	N
History of Breast Cancer?	☐	☐
Colon Cancer?	☐	☐
Other Cancers?	☐	☐
Heart Disease?	☐	☐
High Blood Pressure?	☐	☐
Diabetes?	☐	☐
Bleeding Disorder?	☐	☐
Reaction to Anesthesia?	☐	☐

Health Screening:
When did you last have the following exams?
Complete Physical Exam:
Flex Sigmoid Exam:
Chest Xray:
Rectal Exam:
Pelvic Exam:
Mammogram:
EKG :
Echocardiogram:
Cardiac Stress Test:

Review of Systems: *Please check the box if you have any history of the problems listed below:*

General Symptoms:
- ☐ *Weight loss over 10 lbs.*
- ☐ *Fever or Chills*
- ☐ *Fatigue*
- ☐ *Night Sweats*
- ☐ *Loss of Appetite*

Cardiovascular:
- ☐ *Heart disease*
- ☐ *Chest Pain or Angina*
- ☐ *Palpitations*
- ☐ *Shortness of Breath while lying flat*
- ☐ *Swelling of ankles*
- ☐ *Heart Murmur*
- ☐ *High Cholesterol*
- ☐ *Heart Attack*
- ☐ *Pacemaker*
- ☐ *Congestive Heart Failure*
- ☐ *Stroke*
- ☐ *Leg cramps or pain with walking*

Eyes:
- ☐ *Eye disease or injury*
- ☐ *Wear glasses or contacts*
- ☐ *Blurred or Double Vision*
- ☐ *Glaucoma*
- ☐ *Cataracts*

Skin and Breast:
- ☐ *Rash or Itching*
- ☐ *Easy Bruising*
- ☐ *Change in Hair or Nails*
- ☐ *Changes in Moles*
- ☐ *Sores that will not heal*
- ☐ *Varicose Veins*
- ☐ *Breast Pain*
- ☐ *Breast Lumps*
- ☐ *Breast Discharge*
- ☐ *Abnormal Mammogram*

Respiratory:
- ☐ *Chronic Cough*
- ☐ *Shortness of Breath*
- ☐ *Coughing up Blood*
- ☐ *Wheezing*
- ☐ *Emphysema*
- ☐ *Asthma*
- ☐ *Pneumonia*
- ☐ *Tuberculosis or TB*

Ears, Nose, and Throat:
- ☐ *Hearing Loss*
- ☐ *Nose Bleeds*
- ☐ *Mouth Sores*
- ☐ *Hoarseness*
- ☐ *Difficulty Swallowing*
- ☐ *Swollen Glands in Neck*
- ☐ *Goiter*

Continued on Back

Review of Systems: (Continued) *Please check the box if you have any history of the problems listed below:*

Gastrointestinal:
- ☐ *Nausea or Vomiting*
- ☐ *Change in Bowel Movements*
- ☐ *Frequent Diarrhea*
- ☐ *Constipation*
- ☐ *Painful Bowel Movements*
- ☐ *Rectal Bleeding or Blood in Stool*
- ☐ *Abdominal Pain*
- ☐ *Vomiting Blood*
- ☐ *Frequent Heartburn*
- ☐ *Jaundice*
- ☐ *Hepatitis*
- ☐ *Liver Disease*
- ☐ *Stomach or Duodenal Ulcers*

Musculoskeletal:
- ☐ *Joint Pain or Stiffness*
- ☐ *Weakness of Muscles*
- ☐ *Muscle Pain or Cramps*
- ☐ *Back Pain*
- ☐ *Leg Pain with walking*
- ☐ *Gout*
- ☐ *Hip or Knee joint replacement*

Psychiatric:
- ☐ *Nervousness or Anxiety*
- ☐ *Depression*
- ☐ *Insomnia*
- ☐ *Drug Abuse*
- ☐ *Alcohol Abuse*

Genitourinary:
- ☐ *Frequent Urination*
- ☐ *Blood in Urine*
- ☐ *Incontinence or Dribbling*
- ☐ *Kidney Stones*
- ☐ *Frequent Urination at Night*
- ☐ *Prostate Problems*
- ☐ *Kidney Disease or Failure*

Gynecological:
- ☐ *Irregular or Heavy Periods*
- ☐ *Bleeding between Periods*
- ☐ *# of Pregnancies:*
- ☐ *# of Miscarriages:*
- ☐ *Date of Last Period:*

Hematology/Lymphatic:
- ☐ *Slow to heal after cuts*
- ☐ *Bleeding or Bruising tendency*
- ☐ *Anemia*
- ☐ *Previous Blood Transfusion*
- ☐ *Enlarged Glands or Lymphnodes*
- ☐ *AIDS or HIV positive*

Allergic/Immunologic: *List the things you are allergic to*
- ☐ *Allergy to Penicillin or other Antibiotic?*
- ☐ *Allergy to Iodine or IVP dye?*
- ☐ *Allergy to Novocaine or other Local Anesthetics?*
- ☐ *Food Allergies?*
- ☐ *Reaction to General Anesthesia?*

Neurological:
- ☐ *Frequent Headaches*
- ☐ *Dizziness*
- ☐ *Seizures*
- ☐ *Numbness or Tingling Sensations*
- ☐ *Tremors*
- ☐ *Paralysis*
- ☐ *Head Injury*
- ☐ *Stroke*
- ☐ *Black-out Spells*
- ☐ *Weakness in Arms or Legs*
- ☐ *Confusion*
- ☐ *Memory Loss*

Endocrine:
- ☐ *Glandular or Hormonal problems*
- ☐ *Excessive Thirst or Urination*
- ☐ *Heat or Cold Intolerance*
- ☐ *Skin becoming drier*
- ☐ *Diabetes*
- ☐ *Goiter*
- ☐ *Thyroid Nodule*
- ☐ *Thyroid problems*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform this doctor's office of any changes in my medical history. I authorize the physicians/staff of Surgical Specialists of St. Joseph, P.C. to perform the medical treatments and services that I may need.

______________________________ *Signature of Patient or Guardian*

______________________________ *Date*

(Physician/Nurse section)

BP: **HR:** **RR:** **Temp:** **Weight:** _____ *Nurses Initials*

Physical Exam:

Impression/Plan:

The Patient History form has been reviewed in its entirety by______________________________ **M.D.** **Date:**___ / ___ / ___