Elliot General Surgical Specialists

HEALTH QUESTIONNAIRE

Please print Today's date:______________

Patient Name:_____________________________________SS#_______________________☐M ☐F

Age: ____Birthdate: ____________Height______Weight_____Marital Status:☐M ☐S☐D☐W☐Sep

Primary Care Physician:____

Physician who sent you here:____

Occupation: ____

Reason for your visit today (please describe your injury or problem, in detail)________________________________

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PERSONAL MEDICAL HISTORY: Have you ever had any of the following conditions? Leave blank if uncertain.

Condition			Condition		
Anemia	NO	YES	Hemorrhoids	NO	YES
Arthritis (other than back)	NO	YES	Hepatitis	NO	YES
Asthma/lung disease	NO	YES	High blood pressure/hypertension	NO	YES
Bleeding tendencies	NO	YES	HIV/AIDS	NO	YES
Blood clots	NO	YES	Kidney stones	NO	YES
Blood/plasma transfusions	NO	YES	Kidney failure	NO	YES
Cancer	NO	YES	Liver disease	NO	YES
Colitis	NO	YES	Migraine headaches	NO	YES
Depression	NO	YES	Psoriasis	NO	YES
Diabetes	NO	YES	Rheumatic fever	NO	YES
Exposure to hazardous chemicals	NO	YES	Shingles	NO	YES
Epilepsy	NO	YES	Stomach ulcers	NO	YES
Gall Bladder disease	NO	YES	Stroke	NO	YES
Glaucoma	NO	YES	Tuberculosis	NO	YES
Gout	NO	YES	Venereal disease	NO	YES
Heart disease	NO	YES	Thyroid disorder	NO	YES
High Cholesterol	NO	YES	Other ______________________		
History of MRSA	NO	YES	______________________		

OPERATIONS/ HOSPITALIZATIONS: **Reason:** **Date:**

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ALLERGIES:					
Shellfish	NO	YES	X-ray Contrast/dye	NO	YES
Latex	NO	YES	Local Anesthetic	NO	YES

MEDICATION ALLERGIES:____

CURRENT MEDICATIONS:

Name:	**Dose:**	**Frequency:**	**Reason:**

FAMILY HISTORY: List immediate family members with the following:

Diabetes	NO	YES____
Cancer	NO	YES____
Gout	NO	YES____
Heart disease	NO	YES____
Hypertension	NO	YES____
Other (Specify)	NO	YES ____

HEALTH HABITS/DIETARY SUPPLEMENTS: **Explain:**

Vitamins	NO	YES________________
Calcium	NO	YES________________
Estrogen	NO	YES________________
Tobacco	NO	YES (Type/Amount per day)________________
Have you ever smoked	NO	YES (if you quit, date you quit)________________
Alcohol	NO	YES________________
Drug Use	NO	YES (Type/Frequency)________________
History of drug or alcohol abuse	NO	YES (describe)________________
Caffeine	NO	YES (Type/Frequency)________________
Exercise	NO	YES (Type/Frequency)________________

REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the past six months.

Weight gain-more than 10 lbs.	NO	YES
Weight loss-more than 10 lbs.	NO	YES
Appetite change	NO	YES
Marked fatigue	NO	YES
Unexplained night fever	NO	YES
Night sweats	NO	YES
Difficulty sleeping	NO	YES
Psychological difficulties	NO	YES
SKIN/BREASTS:		
Rash or itching	NO	YES
Pain	NO	YES
Skin change	NO	YES
Breast lump	NO	YES
Breast discharge	NO	YES
RESPIRATORY SYSTEM:		
Chest pain	NO	YES
Recurring cough	NO	YES
Wheezing	NO	YES
Shortness of breathe	NO	YES
CARDIOVASCULAR SYSTEM:		
Chest pain/tightness/pressure	NO	YES
Palpitations	NO	YES
Lightheadedness/fainting	NO	YES
EYES/EARS/NOSE/MOUTH/THROAT:		
Chronic sinus problems	NO	YES
Hearing loss/ ringing	NO	YES
Nose bleeds	NO	YES
Blurred or double vision	NO	YES
ENDOCRINE:		
Liver disease	NO	YES
Jaundice	NO	YES
High cholesterol	NO	YES
Hepatitis	NO	YES
Diabetes	NO	YES
Thyroid problem	NO	YES
GASTROINTESTINAL SYSTEM:		
Persistent recurring belly pain	NO	YES
Uncontrolled loss of stool	NO	YES
Heartburn/indigestion	NO	YES
Pain with bowel movement	NO	YES
Diarrhea	NO	YES
Blood in stool	NO	YES
Constipation	NO	YES
Yellow jaundice	NO	YES
UROLOGICAL SYSTEM:		
Difficulty with urination	NO	YES
Pain/burning on urination	NO	YES
Uncontrolled loss of urine	NO	YES
Urinary tract infection	NO	YES
SKELETAL SYSTEM:		
Joint pain	NO	YES
Joint stiffness	NO	YES
Joint redness	NO	YES
Joint swelling	NO	YES
NERVOUS SYSTEM:		
Tremors	NO	YES
Headaches	NO	YES
Numbness	NO	YES
Dizziness/vertigo	NO	YES
Seizures	NO	YES
HEMATOLOGIC/LYMPHATIC:		
Anemia	NO	YES
Blood Transfusion	NO	YES
Sickle cell trait or disease	NO	YES
Enlarged glands	NO	YES
Mononucleosis	NO	YES
Varicose veins/clots/phlebitis	NO	YES
Bleeding disorder	NO	YES

Any other information of which the doctor should be aware? ________________________________

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To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status.

Signature: Date:

PHYSICIAN USE ONLY: reviewed by________________________**Date:**____________

Revised 10/04