$Surgical\ Associates\ of\ Fredericksburg,\ Ltd.$

HEALTH HISTORY FORM

(All information will remain confidential)

Name	Today's Date			
Age Date of birth _	Sex			
Reason for visit		Weight	Height	
PAST MEDICAL HISTORY	Check items where previous his	story applies.		
□ Abdominal Aneurysm □ Anal Fissure/Ulcer □ Arterial Disease □ Asthma □ Atrial Fibrillation □ Atherosclerosis □ High Blood Pressure (Hypertension) □ Benign prostate hyperplasia □ Bowel Obstruction □ Breast Cancer □ Irregular Heart Beat List other conditions here.	□ Carotid Artery Stenosis □ Cataracts □ Stroke □ MS/Muscular Dystrophy □ Migraine Headaches □ Colon Cancer □ Colon Polyps □ Crohn's Disease □ Congestive Heart Failure □ COPD □ Degenerative Disc Disease	 □ Diabetes Mellitus, Type I □ Diabetes Mellitus, Type II □ Diabetic Neuropathy □ Diverticulitis of Colon □ End Stage Renal Disease □ Gallstones □ Heartburn □ Heart Disease □ Hiatal Hernia □ High Cholesterol 	☐ Irritable Bowel/Spastic Colon ☐ Kidney Stone ☐ Liver Disease ☐ Lung Cancer ☐ Osteoporosis ☐ Peptic Ulcer Disease ☐ Pilonidal Cyst ☐ Previous Heart Attack ☐ Rectal Abscess ☐ Sleep Apnea ☐ Ulcerative Colitis ☐ Venous (vein) Disease ☐ Wound Infection Post Surgery	
PAST SURGICAL HISTORY Abdominal Aneurysm Abdominal Hernia Anal Fissure/Ulcer Appendectomy Arterial Bypass, Leg Back Surgery Cardiac Stents Cataract Surgery C-Section List other surgeries here:	Please check or list all previou Cholecystectomy (Gallbladd Clotting/Bleeding Disorder Colectomy Coronary Artery Bypass Dialysis Access Dilation and Curettage (D&C DVT or Pulmonary Embolus Bowel Surgery Heart Valve Replacement	ler) Hemorrhoidectomy Hip Replacement Hysterectomy Inguinal Hernia Knee Surgery Lithotripsy	ery adjacent to operation. Ovarian Cyst Drainage Pacemaker/Defibrillation Prostate Surgery Rectal Abscess Thyroidectomy Tonsillectomy Umbilical Hernia	
MEDICATION LIST List all current prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort). Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin.)				
NAME OF MEDICATION	DOSE	HOW OFTEN DO YOU TAKE?	REASON FOR MEDICATION	!?
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(Please see reverse side for Page 2)

ALL INFORMATION IS IMPORTANT PLEASE COMPLETE ALL SECTIONS **DRUG ALLERGY LIST** Please check/list all medications or vaccinations that have caused an allergic reaction in the past: ☐ Penicillin ☐ Sulfa Drugs ☐ IV/Dye ☐ Novacaine/Lidocaine ☐ Codeine ☐ No Known Drug Allergies ☐ Other, Please List **LATEX ALLERGY?** Are you allergic to latex? ☐ Yes ☐ No **ANESTHESIA PROBLEMS?** Have you had any previous difficulties with general anesthesia or sedation? \square Yes \square No If yes, please provide detail below **PREGNANCY?** Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly FAMILY HISTORY Check if any of your blood relatives have had any of the following conditions: Indicate Relationship to You(Maternal or Paternal) Indicate Relationship to You ☐ Ischemic Heart Disease ☐ Stroke ☐ Breast Cancer ☐ Kidney Disease □ Colon Cancer □ Ovarian Cancer ☐ Colon Polyps ☐ Regional Enteritis (Crohn's Disease) ☐ Diabetes Mellitus ☐ Thyroid Cancer ☐ Other: ☐ Other: ☐ Other: ☐ Other: SOCIAL HISTORY Check which substances you use and how much you use: ☐ Alcohol, no use ☐ Alcohol, heavy use ☐ Tobacco, 1 ppd ☐ Other ☐ Tobacco, no use ☐ Chewing Tobacco ☐ Tobacco, 1.5 ppd ☐ Tobacco, former smoker ☐ Alcohol, rare use Yrs ☐ Tobacco, 2.0 ppd ☐ Illegal Drugs, specify: ☐ Alcohol, moderate use ☐ Tobacco, ½ ppd ☐ Tobacco, > 2 ppd **REVIEW OF SYSTEMS** Check symptoms you CURRENTLY have or ARE ASSOCIATED WITH THE REASON FOR YOUR VISIT. RESPIRATORY **GENERAL BREASTS GENITOURINARY** MUSCULOSKELETAL □ Fever ☐ Lumps ☐ Shortness of breath ☐ Blood in urine ☐ Limitation of Motion □ Tenderness ☐ Chills ☐ Wheezing ☐ Incontinence ☐ Muscular Weakness ☐ Weight Loss ☐ Swelling ☐ Cough □ Urinary retention ☐ Muscle Cramps ☐ Nipple Discharge ☐ Weight Gain ☐ Hoarseness ☐ Difficulty voiding ☐ Other: □ Fatigue □ Rash/Scaling ☐ Coughing up blood □ Urinary hesitancy **ENDOCRINE** ☐ Loss of Appetite ☐ Irregular period ☐ Nipple Retraction ☐ Sleep Apnea □ Cold intolerance ☐ Other: ■ Malaise ☐ Anesthetic Problems □ Vaginal discharge ☐ Heat intolerance **CARDIOVASCULAR** ☐ Possible pregnancy □ Body Aches GASTROINTESTINAL ☐ Weight Gain ☐ Weight Loss ■ Night Sweats ☐ Chest Pain ☐ Scrotal mass ☐ Loss of appetite ☐ Other: ☐ Other: ☐ Irregular Heart Beat ☐ Feel full after eating ☐ Hot Flashes ☐ Rapid Heart Rate small amounts of food SKIN ☐ Other: □ Blurred Vision ☐ Shortness of Breath ☐ Heartburn □ Rash **PSYCHIATRIC** ☐ Impaired Vision w/ exercise ☐ Difficulty Swallowing ☐ Itching □ Anxiety ☐ Depression ☐ Double Vision ☐ Shortness of Breath ☐ Painful Swallowing ☐ New Skin Lesions ☐ Vomiting Blood □ Hallucinations ☐ Eye Pain when lying down ☐ Changes to Skin Lesions ☐ Other: ☐ Episodes of ☐ Nausea ☐ Other: ☐ Other: Head, Ear, Nose, Throat unconsciousness □ Vomiting **NEUROLOGIC HEME-LYMPH** ☐ Sore Throat □ Bloating □ Easy bleeding ☐ Shortness of Breath ☐ Tingling or numbness ☐ Headaches at nighttime □ Diarrhea □ Weakness □ Easy bruising ☐ Vertigo (dizziness) ☐ Constipation ☐ Tiny red spots on skin ☐ Lower extremity swelling ☐ Poor coordination

☐ Abdominal Pain

☐ Blood in stool

☐ Other:

☐ Urgency

☐ Frequency

☐ Black, tarry stool

□ Painful Urination

☐ Jaundice-yellow skin, eyes

GENITOURINARY

☐ Lower extremity blueness

☐ Leg pain with walking

☐ Dizziness when standing

☐ Lightheadedness

☐ Other:

☐ Varicose veins

□ Venous cords

□ Speech difficulties

MUSCULOSKELETAL

☐ Loss of Balance

☐ Other:

☐ Bone Pain

☐ Back Pain

☐ Joint Pain

☐ Muscle Pain

☐ Purple areas on skin

☐ Lymph node swelling

☐ Frequent Infections ☐ Other:_____

ALLERGIC/IMMUNOLOGIC

☐ Other:

☐ Sinus Allergies☐ Allergic dermatitis

☐ Lightheaded

☐ Dentures

☐ Neck Pain☐ Thyroid Mass

☐ Hearing Loss

☐ Other:

☐ Dental Problems

☐ Recent Head Injury