Precision Surgical Consultants, LLC

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HEALTH HISTORY (1 of 2)

PATIENT NAME:_____ **DOB:**_____ **AGE:**_____
To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

Today's Date:_____ **When was your last physical exam?**_____
Referring Physician:_____ **Referring Physician Phone Number:**_____

PAST MEDICAL HISTORY— Have you ever had the following? (Please check "YES"or "NO")

MALADY	NO	YES	MALADY	NO	YES
AIDS or HIV	○	○	High B/P	○	○
Anemia	○	○	Low B/P	○	○
Arthritis	○	○	Hemorrhoids	○	○
Asthma	○	○	Hernia	○	○
Back Trouble	○	○	Infectious Mono	○	○
Bladder Infection	○	○	Kidney Disease	○	○
Blood/Plasma Infusion	○	○	Pneumonia	○	○
Bronchitis	○	○	Rheumatic Fever	○	○
Cancer	○	○	Stroke	○	○
If yes, type of cancers:_____			Tuberculosis	○	○
Diabetes	○	○	Ulcer	○	○
Epilepsy	○	○	Venereal Disease	○	○
Glaucoma	○	○			
Heart Disease	○	○			
Hepatitus	○	○			

Any other diseases or illness:
_____

PAST SURGICAL HISTORY—Please list ALL serious illnesses, operations, and other hospitalizations you have experienced (checkboxes) along with type and years these occurred. If uncertain, leave blank.

MALADY	TYPE	DATE
☐ Abdominal surgery	_____	_____
☐ Breast surgery	_____	_____
☐ Colonoscopy	_____	_____
☐ Heart surgery	_____	_____
☐ Hemorrhoidectomy	_____	_____
☐ Hernia surgery	_____	_____
☐ Hysterectomy	_____	_____
☐ Larynogoscopy	_____	_____
☐ Pacemaker insertion	_____	_____
☐ Spinal surgery	_____	_____
☐ **Any other surgeries	_____	_____

Please list ALL ALLERGIES (food, drug, and environmental):
_____

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HEALTH HISTORY (2 of 2)

PLEASE LIST ALL MEDICINES YOU ARE CURRENTLY TAKING INCLUDING OTC AND VITAMINS:

_____

_____

SOCIAL HISTORY: Marital Status: ◯ S ◯ M ◯ D ◯ W

ACTIVITY	TYPE	AMOUNT
☐ Smoking:	_____	_____ per WEEK
☐ Alcohol:	_____	_____ per WEEK
☐ Caffeine:	_____	_____ per DAY
☐ Street drugs:	_____	_____ per DAY

If former smoker, date quit: _____

FAMILY HISTORY—Has any blood relative had any of the following? (check box); leave blank if uncertain.

MALADY	RELATIONSHIP	
☐ Asthma	_____	
☐ Cancer	_____	Type: _____
☐ Chronic lung disease	_____	
☐ Diabetes	_____	Type: _____
☐ Heart disease	_____	
☐ High blood pressure	_____	
☐ Mental illness	_____	
☐ Stroke	_____	
☐ Tuberculosis	_____	

REVIEW OF SYSTEMS—Do you have now or have you had any of these problems within the last year?

SKIN	EYES	RESPIRATORY	ALLERGY-IMMUNITY	PSYCHIATRIC
☐ Rash	☐ Changed vision	☐ Wheezing	☐ Sinus allergy symptoms	☐ Anxiety
☐ Itching	☐ Blurred vision	☐ Shortness of breath	☐ Frequent illnesses	☐ Depression
☐ New skin lesions	☐ Double vision	☐ Coughing		

MUSCULOSKELETAL	CONSTITUTION	CARDIOVASCULAR	HEME-LYMPH	GENITOURINARY
☐ Bone pain	☐ Fever	☐ Chest pain	☐ Easy bleeding	☐ Urgency
☐ Back pain	☐ Chills	☐ Cardiac murmurs	☐ Easy bruising	☐ Frequency
☐ Joint pain	☐ Weight loss	☐ Irregular heartbeat	☐ Lymph node enlargement or tenderness	☐ Dysuria
☐ Muscle pain	☐ Fatigue	☐ Dysnea or exertion		☐ Nocturia

HEAD	NEUROLOGIC	BREAST	GASTROINTESTINAL	ENDOCRINE
☐ Sinus pain	☐ Seizure	☐ Skin rash	☐ Nausea	☐ Polyuria
☐ Headaches	☐ Tingling	☐ Nipple discharge	☐ Vomiting	☐ Polydipsia
☐ Vertigo	☐ Numbness	☐ Nipple inversion	☐ Diarrhea	☐ Cold intolerance
☐ Lightheadedness	☐ Tremors	☐ Skin dimpling/puckering	☐ Constipation	☐ Heat intolerance
☐ Recent head injury	☐ Change in coordination	☐ Lumps	☐ Changed bowel habits	☐ Weight gain
		☐ Tenderness	☐ Blood in stool	☐ Weight loss
			☐ Change in abdominal girth	