

Patient Name: _____

SURGICAL HISTORY - List any serious injuries or surgical procedures, and approximate year.								
Procedure		Year	Procedure		Year	Procedure		Year
<input type="checkbox"/>	Appendectomy		<input type="checkbox"/>	Heart Surgery (Type):		<input type="checkbox"/>	Pacemaker	
<input type="checkbox"/>	Aneurysm					<input type="checkbox"/>	Prostate	
<input type="checkbox"/>	Bladder					<input type="checkbox"/>	Reflux Surgery	
<input type="checkbox"/>	Bowel Surgery		<input type="checkbox"/>	Hemorrhoid Surgery		<input type="checkbox"/>	Skin Surgery	
<input type="checkbox"/>	Brain		<input type="checkbox"/>	Hernia Surgery		<input type="checkbox"/>	Spinal Surgery	
<input type="checkbox"/>	Breast		<input type="checkbox"/>	Hysterectomy		<input type="checkbox"/>	Stent Placement	
<input type="checkbox"/>	CABG		<input type="checkbox"/>	Joint replacement:		<input type="checkbox"/>	Sterilization; Type	
<input type="checkbox"/>	Carotid					<input type="checkbox"/>	Testicles	
<input type="checkbox"/>	Carpal Tunnel					<input type="checkbox"/>	Thyroidectomy	
<input type="checkbox"/>	Colonoscopy		<input type="checkbox"/>	Kidney		<input type="checkbox"/>	Tonsillectomy	
<input type="checkbox"/>	Cosmetic Surgery		<input type="checkbox"/>	Liver Biopsy		<input type="checkbox"/>	Transplant Surgery	
<input type="checkbox"/>	C-Section		<input type="checkbox"/>	Liver Surgery		<input type="checkbox"/>	Upper Endoscopy (EGD)	
<input type="checkbox"/>	ERCP		<input type="checkbox"/>	Lung Surgery		<input type="checkbox"/>	Valve Replacement	
<input type="checkbox"/>	Eye Surgery		<input type="checkbox"/>	Orthopedic Surgery:		<input type="checkbox"/>	Varicose Veins	
<input type="checkbox"/>	Gallbladder Surgery					<input type="checkbox"/>	Other	
<input type="checkbox"/>	Gastric Surgery					<input type="checkbox"/>	Other	

HOSPITALIZATIONS - Non-surgical, please provide reason	
Date _____	Reason: _____
Date _____	Reason: _____
Date _____	Reason: _____
Date _____	Reason: _____

FAMILY MEDICAL HISTORY							
<input type="checkbox"/> Adopted	Mother	Father	Sibling:	Sibling:	Sibling:	Child	Child
Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased Age:							
Barrett's Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine, Bladder, Ureter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____

Caffeine/Tabacco/Drug/Alcohol Use	Do you currently use tabacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No		For how long? _____	
	<input type="checkbox"/> Cigarettes _____ packs per day	<input type="checkbox"/> Cigar/Pipe _____ amount per day	<input type="checkbox"/> Chewing _____ amount per day	
	Have you ever tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Have you previously used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No		For how long?	
	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigar/Pipe	<input type="checkbox"/> Chewing	When did you quit?
	Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Beer:	<input type="checkbox"/> Occasional <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Never		
	Wine:	<input type="checkbox"/> Occasional <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Never		
	Liquor:	<input type="checkbox"/> Occasional <input type="checkbox"/> Weekly <input type="checkbox"/> Daily <input type="checkbox"/> Never		
	Do you consume drinks containing Caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If yes, how many drinks do you consume per day _____			
	Drug use:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____	Last Usage _____
Have you ever been treated for addiction?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Personal	Education	
	How many children do you have?	How many children at home?
	Type of Exercise? _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
	Lives With	
	Occupation	<input type="checkbox"/> Full Time <input type="checkbox"/> Part time
	Religious Preference	

Vaccines	Last Flu Vaccination	Date
	Last Pneumonia (Circle: Prevar 13 and/or Pneumovax 23) Vaccination(s)	Date
	Last Shingles (Zostavax) Vaccine	Date
	Last Tetnus (Circle: Tdap or Td) Vaccine	Date
	HepatitisB Vaccine, Did you complete the series? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates:

Screenings	Last Breast Cancer Screening (Mammogram)	Date
	Last Abdominal Aortic Aneurysm (AAA) Screening	Date
	Last Lung Cancer Screening	Date
	Last Bone Density Screening (DEXA)	Date
	Last Prostate Cancer Screening (PSA)	Date

Testing	Diagnostic Testing - List any imaging you have had pertaining to the curent issues					
		Ultrasound	CT Scan	MRI	Labs	Other
	Date					
	Where					

Specialists	Please list all doctors you currently see			
	Name	Specialty	Address	Phone