

HEALTH HISTORY
SURGICAL ASSOCIATES OF RICHMOND

Acct # _____ Today's Date: ___/___/_____
Name: _____ Birth Date: ___/___/___ Gender: M or F Race: _____ Ethnicity: _____ Preferred
Language: _____ Reason for your visit today: _____
_____ How long have you had this problem? ___ Yrs ___ Mos, Your Primary Care Physician? _____

REVIEW OF SYSTEMS

(Circle any symptoms that you have now or have had within the past month)

GENERAL: Chills, Fatigue, Fever, Night sweats, Weight loss

SKIN: Bruising, Hives, Rash

HEENT: Blurred vision, Double vision, Visual loss, Hoarseness, Sore throat

RESPIRATORY: Bloody sputum (cough), Cough, Difficulty breathing (shortness of breath), Wheezing, Waking up from sleep wheezing or short of breath (sleep apnea)

CARDIOVASCULAR: Chest pain, Leg cramps, Leg pain &/or swelling (or foot pain at rest), Palpitations, Swelling of extremities (ankle foot)

GASTROINTESTINAL: Abdominal pain, Bloody stool, Change in bowel habits (change in stool caliber or color), Constipation, Diarrhea, Food intolerance (no appetite), Nausea, Vomiting blood

FEMALE GENITOURINARY: Blood in urine, Difficulty emptying bladder, Excessive menstrual bleeding, Menstrual irregularities, Painful urination, Urinating at night, Vaginal bleeding

MUSCULOSKELETAL: Back pain, Joint pain (aches), Muscle cramps, Muscle pain (aches)

NEUROLOGICAL: Difficulty speaking, Headaches, Numbness, Trouble walking (or limited ability to walk), Weakness in extremities (of arms and legs)

PSYCHIATRIC: Anxiety, Depression (sadness, hopelessness), Memory loss

ENDOCRINE: Cold intolerance, Excessive thirst, Excessive urination, Heat intolerance

HEMOTOLOGY: Gland problems (swollen lymph glands)

PAST MEDICAL HISTORY

(Please circle all that apply)

Abdominal Problems

Last Colonoscopy:
(Date) ___/___/_____
Diverticulitis
Diverticulosis

Intestinal Cancer
Jaundice/Hepatitis
Esophageal Reflux

Breast Diseases

Last Mammogram:
(Date) ___/___/_____
Cancer
Lumps
Fibrocystic
Nipple Discharge

Endocrine

Diabetes
Thyroid Problem
Eye Problem
Glaucoma

Gynecologic Problems

Infections
Cancer
Endometriosis
Bleeding
of Pregnancies _____
of Live Births _____
History of Breast Feeding
Last Menstrual Period:
(Date) ___/___/_____
Last Pap Test: ___/___/___

Heart Problems

Angina
Heart Attack
Irregular Rhythm
High Blood Pressure
Heart Murmur
Enlarged Heart
Congestive Heart Failure

Hematologic Problems

Bleeding Disorder
Anemia
Kidney/Urinary Problems
Stones
Frequent Infections
Prostate

Lung Problems

Asthma
Shortness of Breath
Emphysema
Pulmonary Embolus
TB
Sleep apnea

Neurologic Problems

Stroke
Seizure
Orthopedic Problems
Fracture
Artificial Joint
Arthritis
Osteoporosis

Psychiatric Problems

Circle yes or no
Skin Problems
Skin Cancer
Vascular Disease Ulcer
Phlebitis/Blood Clots
Carotid Disease
Varicose Veins
Immunizations
Influenza Vaccine Y / N
(Date) ___/___/_____
Pneumonia Vaccine Y / N
(Date) ___/___/_____
Ulcer

SOCIAL HISTORY

Are you a smoker? Y or N
How many years? _____
How many packs per day? _____
Do you drink alcohol? Y or N
Marital Status _____
Occupation _____
Are you HIV Positive? Y or N
Have you had an HIV test? Y or N

SURGICAL HISTORY

(if more than two surgeries, please inform receptionist)

Previous Surgery: _____

& approximate year: _____

Previous Surgery: _____

& approximate year: _____

FAMILY HISTORY

(Circle all that apply)

Breast Cancer
Colon Cancer
Prostate Cancer
Ovarian Cancer
Diabetes
Heart Disease
Stroke
High Blood Pressure
Other Cancer _____

Medications:

_____ mg _____ per day
_____ mg _____ per day
_____ mg _____ per day

(if more than three medications, please inform receptionist)

Vitamins:

_____ mg _____ per day
_____ mg _____ per day

Herbs:

_____ mg _____ per day
_____ mg _____ per day

No Allergies ? - (circle YES)

Allergies – Environmental _____

Allergies – Food _____

Allergies – Medications _____