

HEALTH HISTORY
For your visit with
SURGICAL ASSOCIATES OF RICHMOND

Acct # _____
Name _____ Age _____ Today's Date _____
Reason for your visit today _____

How long have you had this problem? _____

PAST MEDICAL HISTORY

(Please circle all that apply)

Neurologic Problems Stroke Seizure	Lung Problems Asthma Shortness of Breath Emphysema Pulmonary Embolus TB	Abdominal Problems Diverticulitis Diverticulosis Ulcer Intestinal Cancer Jaundice/Hepatitis Esophageal Reflux	Kidney/Urinary Problems Stones Frequent Infections Prostatic
Endocrine Diabetes Thyroid Problem	Orthopedic Problems Fracture Artificial Joint Arthritis Osteoporosis	Breast Diseases Cancer Lumps Fibrocystic Nipple Discharge	Psychiatric Problems Circle yes or no
Eye Problem Glaucoma	Vascular Disease Phlebitis/Blood Clots Carotid Disease Varicose Veins	Skin Problems Skin Cancer	Gynecologic Problems Infections Cancer Endometriosis # of Pregnancies _____ # of Live Births _____ History of Breast Feeding Last Menstrual Period (Date) ____/____/____ Last Mammogram ____/____/____ 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	

SOCIAL HISTORY

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

Medications:

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

Vitamins:

_____ mg _____ per day
_____ mg _____ per day

Herbs:

_____ mg _____ per day
_____ mg _____ per day

FAMILY HISTORY (Circle all that apply)

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

Previous Surgeries:

& approx. year _____

Allergies/Reactions: _____

REVIEW OF SYSTEMS

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

GENERAL: Fever, chills, night sweats, weight loss, persistent fatigue

SKIN: Rash, hives, bruising

EYE: Blurred/double vision, loss of vision, sore throat, hoarseness

CARDIOVASCULAR: Chest pain, palpitations, ankle/foot swelling, limited ability to walk, foot pain at rest, leg cramps

PULMONARY: Shortness of breath, wheeze, cough, bloody cough

GI: Nausea, vomiting, vomiting blood, loss of appetite, abdominal pain, diarrhea, constipation, blood in stool, change in stool caliber or color

UROLOGIC/GYN: Difficult, painful, frequent or nocturnal urination, blood in urine, irregular or heavy menses, post-menopausal bleeding

MUSCULOSKELETAL: Muscle or joint aches, back pain, muscle cramps

NEUROLOGIC: Headache, difficulty speaking, memory loss, weakness or numbness of arms and legs

PSYCHIATRIC: Anxiety, depression (sadness, hopelessness)

LYMPHATIC: Swollen lymph glands

ENDOCRINE: Heat or cold intolerance, excessive thirst