NORTHERN REGIONAL HOSPITAL

Northern General Surgery Patient Health History Form

Name:_____

Past Medical History- Have you ever had any of the following?

	Yes	No	Details
Arthritis			_____
Asthma			_____
Bleeding Problem			_____
Cancer (Please list type)			_____
COPD			_____
Diabetes			_____
Fibromyalgia			_____
Gout			_____
Heart Disease			_____
Hepatitis			_____
High Blood Pressure			_____
HIV			_____
Inheritated Illness			_____
Problems with Anesthesia			_____
Seizures			_____
Sleep Apnea			_____
Sexually Transmitted Disease			_____
Thyroid Problems			_____

Past Surgical History- Please any surgeries that you have had.

_____

_____

_____

_____

_____

_____

Medications-Please list all prescription and over the counter medications you take. Please list name of medication,dose and how you take it.

_____

_____

_____

_____

_____

_____

Allergies- Please list anything you have had an allergic reaction to.
Medications:_____
_____
Food:_____
Enviromental:_____

Family Medical History- List illness and relationship to you .
_____
_____
_____
Social History-
1. Do you have a history of abuse or domestic violence?_____
2. Are you currently a victim of abuse or domestic violence?_____
3. When was your last visit with your family doctor?_____
4. What is your preferred language?_____
5. Do you use alcohol? _____How Often?_____
6. Tobacco Use- Please circle one- Never Former Current Everyday Current Sometimes
7. Do you have any Advances Directives? ?_____
8. Do you have a history of falls?_____
9. Have you ever had a colonoscopy? _____ If yes, date?_____
10.Have you ever had a screening mammogram? _____ If yes, date?_____
11. Do you have any suicidal thoughts/tendencies?_____
12. Are you an organ donor?_____
13. Do you have any cultural, religious or emotional barriers to learning?_____

1. Reason for todays visit:_____
2. How long have you had this problem? _____
3. Do you have pain?_____ Location_____Rating_____out of 10
4. When does the problem occur?_____
5. Do you have other symptoms with the problem?_____
_____

Review of Systems:

	Yes	No	Details			
Have you had			_____			
Fever			_____			
Weight Loss			_____			
Fatigue			_____			
Loss of appetite			_____			
Weakness			_____			
Eye problems			_____			
Changes in vision			_____			
Hoarse			_____			
Hearing loss			_____			

	Yes	No	Details			
Chest pain			_____			
Cardiac murmurs			_____			
Irregular heart beats			_____			
Swelling			_____			
Shortness of breath			_____			
Cough			_____			
Coughing up blood			_____			
Heartburn			_____			
Problems swallowing			_____			
Nausea			_____			
Vomiting			_____			
Diarrhea			_____			
Constipation			_____			
Abdominal pain			_____			
Blood in stool			_____			
Hemorrhoids			_____			
Frequent urination			_____			
Pain on urination			_____			
Rash or sores			_____			
Changes to moles			_____			
Numbness or tingling			_____			
Seizures			_____			
Back pain			_____			
Joint pain			_____			
Muscle pain			_____			
Joint swelling			_____			
Muscle weakness			_____			
Anxiety			_____			
Depression			_____			
Trouble sleeping			_____			
Easy bleeding			_____			
Easy bruising			_____			
Enlarge lymph nodes			_____			
Slow healing			_____			