WAVERLYHEALTH
CENTER

# General Surgery Clinic
## Health History Complete

Name _____ Today's Date_____

Date of Birth _____ Family Doctor _____

Reason for Visit: _____

***Your first visit is to meet the doctor and discuss your medical history. It is unlikely that you will have a procedure done that day.***

**MEDICAL HISTORY** (Please circle all that you have now or have had in the past)

| | | | |
|---|---|---|---|
| AIDS | Depression | Hepatitis | Prostate Problems |
| Alcoholism | Diabetes | Hiatal Hernia | Psychiatric Care |
| Anemia | Diverticulosis | High Cholesterol | Reflux (GERD) |
| Anesthesia Problems | Drug Dependency | High Blood Pressure | Rheumatic Fever |
| Anorexia | Emphysema | History of MRSA | Thyroid Problems |
| Anxiety | Epilepsy | Irregular Pulse | Tuberculosis |
| Arthritis | Glaucoma | Kidney Disease | Ulcers |
| Asthma | Goiter | Liver Disease | Vein Problems |
| Bleeding Problems | Gout | Migraine Headaches | Sleep Apnea |
| Blood Clots | Heart Attack | Mononucleosis | Stroke |
| Bronchitis | Heart Problems | Multiple Sclerosis | Other: |
| Cancer<br>Type: | Hemorrhoids | Polio | |

Testing on heart: □ EKG _____ □ Echo _____ □ Stress Test _____ □ Catheterization/Angiogram _____

**SURGERIES** (surgery, when, where, doctor)

_____

_____

_____

_____

Occupation _____

Marital Status single married widowed divorced other

Tobacco: Type _____ How much? _____

Alcohol: How much? _____ How often? _____

Females: Last Period _____ # of Pregnancies _____ # Live Births _____

Do you have any beliefs, religious or cultural practices that your healthcare team should be aware of in order to provide the best care for you? ___ Yes ___ No

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## FAMILY HISTORY

| | |
|---|---|
| Father: □ Living □ Deceased Year of birth:_____ | Age and cause of death: |
| Mother: □ Living □ Deceased Year of birth:_____ | Age and cause of death: |
| Brothers: # Living: #Deceased:<br>Year(s) of birth:_____<br>Sisters: # Living: # Deceased:<br>Year(s) of birth:_____ | Ages and cause of death: |
| Sons: # Living: # Deceased:<br>Year(s) of birth:_____<br>Daughters: # Living: # Deceased:<br>Year(s) of birth:_____ | Ages and cause of death: |

| Illness | X | Relative/Age of Onset | Illness | X | Relative/Age of Onset |
|---|---|---|---|---|---|
| Alcoholism | | | Heart Attack | | |
| Anemia | | | High Blood Pressure | | |
| Anxiety | | | High Cholesterol | | |
| Asthma | | | Kidney Disease | | |
| Birth Defect | | | Migraine Headaches | | |
| Cancer (specify type) | | | Osteoporosis | | |
| Depression | | | Rheumatoid Arthritis | | |
| Diabetes | | | Stroke | | |
| Epilepsy | | | Thyroid Disorder | | |
| Genetic Disease | | | Other (specify) | | |

Patient Name: _____ DOB: _____

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**SYMPTOMS** (Circle all that you have experienced in the last 3-6 months)

| | | | |
|---|---|---|---|
| Fever | Abdominal Pain | Difficulty Urinating | Prostate Problems |
| Chills | Change in Bowels | Blood in Urine | Blurred Vision |
| Weight Loss | Loss of Appetite | Chronic Fatigue | Sore Throat |
| Weight Gain | Swelling in Ankles | Breast Pain | Nasal Congestion |
| Night Sweats | Cough | Nipple Discharge | Joint Pain |
| Nausea | Productive Cough | Breast Lump | Rashes |
| Vomiting | Trouble Breathing | Trouble Sleeping | Seizures |
| Trouble Swallowing | Chest Pain | Painful Intercourse | Intolerance to Heat |
| Diarrhea | Shortness of Breath | Abnormal Pap | Intolerance to Cold |
| Bloating | Poor Circulation | Heavy Periods | Easy Bruising |
| Indigestion | Pain with Urination | Irregular Periods | Easy Bleeding |
| Constipation | Frequent Urination | Swelling in Testicles | Other: |
| Blood in Stool | Urinary Infections | Pain in Testicles | |

Patient Name: _____ DOB: _____

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**ALLERGIES** (list medication and reaction) □ I have no allergies to medications

_____ _____

_____ _____

## MEDICATIONS

□ I take no medications, vitamins, minerals, or herbs.

Pharmacy Used _____

| Medication Name/Vitamins/Herbs | Dose/Strength | # of pills | How many times a day |
|---|---|---|---|
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Patient Name: _____ DOB: _____