Northwest Georgia Surgical Specialists, PC

Medical History Form

Name _____ _____ _____ Date of visit _____ _____ _____

Last First MI Month Day Year

Date of Birth _____ _____ _____ Age _____ Gender _____ Marital Status _____ Height _____ Weight _____

Month Day Year

Referring Doctor

_____

Reason for Visit _____

_____

_____

_____

PAST MEDICAL HISTORY

Pulmonary/Lung Disease

	Y	N
Emphysema	☐	☐
COPD	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Pneumonia	☐	☐
Sleep Apnea	☐	☐
Tuberculosis	☐	☐

Neurologic/Psychiatric

	Y	N
Depression	☐	☐
Bipolar d/o	☐	☐
Schizophrenia	☐	☐
Anorexia	☐	☐
Bulemia	☐	☐
Binge Eating	☐	☐
Migraines	☐	☐

Cardiovascular/Heart Disease

	Y	N
Angina	☐	☐
Heart Attack	☐	☐
Heart Failure	☐	☐
Irregular rate	☐	☐
Murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Aortic Valve Disease	☐	☐
Pulm. Hypertension	☐	☐
Stroke	☐	☐
TIA	☐	☐
Rheumatic Fever	☐	☐
Peripheral Vasc Dis.	☐	☐
Carotid A Disease	☐	☐

PAST MEDICAL HISTORY

Gastrointestinal Disease

	Y	N
Peptic Ulcer Dis	☐	☐
Diverticulosis	☐	☐
GERD	☐	☐
Hiatal Hernia	☐	☐
Crohns Disease	☐	☐
Ulcerative colitis	☐	☐
Irritable Bowel	☐	☐
Jaundice	☐	☐
Hepatitis	☐	☐
Gallbladder dis	☐	☐
Colon Cancer	☐	☐
Colon Polyps	☐	☐
Esophageal varices	☐	☐
Cirrhosis	☐	☐
Hemorrhoids	☐	☐
Pancreatic disease	☐	☐

Musculoskeletal/Rheumatologic

	Y	N
Fibromyalgia	☐	☐
Collagen Vasc Dis	☐	☐
Scleroderma	☐	☐
Gout	☐	☐
Autoimmune Dis	☐	☐

ENT/Opthalmologic

	Y	N
Glaucoma	☐	☐
Vision Problems	☐	☐
Hearing Loss	☐	☐
Dentures	☐	☐
Caps/Crowns	☐	☐
Loose Teeth	☐	☐
Glasses/Contacts	☐	☐
Chronic Sinusitis	☐	☐

Renal/Kidney Disease

	Y	N
Kidney Stones	☐	☐
Dialysis	☐	☐
UTI	☐	☐
Prostate swelling	☐	☐
Prostate Cancer	☐	☐

Hematologic/Blood Disease

	Y	N
DVT	☐	☐
Pulm Embolus	☐	☐
HIV	☐	☐
Anemia	☐	☐
Leukemia	☐	☐
Lymphoma	☐	☐

Endocrine

	Y	N
Diabetes	☐	☐
Thyroid disease	☐	☐
Adrenal disease	☐	☐
Pituitary disease	☐	☐

Review of Systems

Please indicate if you have had any of the following symptoms in the past 6 months:

General	Y	N
Fevers	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐
Change in appetite	☐	☐
Difficulty Sleeping	☐	☐

Skin	Y	N
Growth on skin	☐	☐
Change in color or size of moles	☐	☐
Bleeding from moles	☐	☐

EENT	Y	N
Frequent Nose Bleeds	☐	☐
Change in vision	☐	☐

Lymphatics	Y	N
Swollen glands/lymph nodes	☐	☐

Endocrine	Y	N
Heat or cold intolerance	☐	☐
Frequent Urination	☐	☐
Excessive thirst	☐	☐

Respiratory	Y	N
Persistant or bothersome cough	☐	☐
Shortness of breath	☐	☐
Coughing up blood	☐	☐

Cardiovascular	Y	N
Chest pain	☐	☐
Swelling in feet	☐	☐
Pain in calf muscle when walking	☐	☐
Irregular heartbeat	☐	☐
Difficulty lying flat to sleep	☐	☐

Gastrointestinal	Y	N
Indigestion/heartburn	☐	☐
Difficulty swallowing	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Blood in stool	☐	☐
Change in bowel habits	☐	☐

Genitourinary	Y	N
Burning or pain with urination	☐	☐
Blood in urine	☐	☐
Difficulty urinating	☐	☐
Bubble or air in urine	☐	☐
Difficulty urinating	☐	☐

Musculoskeletal	Y	N
Joint pain or stiffness	☐	☐

Central Nervous System	Y	N
Frequent headaches	☐	☐
Seizures	☐	☐

Surgical History

Abdominal

- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Gastrectomy
- ☐ Small Bowel Resection
- ☐ Splenectomy
- ☐ Surgery for bowel obstruction
- ☐ Hernia

specify _____

Bariatric Surgery

- ☐ Gastric bypass
- ☐ Gastric Band
- ☐ Sleeve Gastrectomy
- ☐ Duodenal Switch
- ☐ VBG

Breast Surgery

- ☐ Mastectomy
- ☐ Breast Biopsy
- ☐ Lumpectomy
- ☐ Breast Implant
- ☐ Tram reconstruction

Other Surgical Procedures:

_____

_____

_____

_____

Pelvic Surgery

- ☐ Hysterectomy
- ☐ Removal of Ovary
- ☐ Ectopic Pregancy
- ☐ C section

☐ **Amputation**

specify _____

Head/Neck Surgery

- ☐ Tonsillectomy
- ☐ Thyroid surgery
- ☐ Ear surgery

Vascular Surgery

- ☐ Aneurysm
- ☐ Carotid
- ☐ Other _____

Orthopedic Surgery

- ☐ Hip replacement
- ☐ Rotator cuff repair
- ☐ Knee replacement
- ☐ Knee surgery, other

☐ **Have you ever had problems with general anesthesia?**

☐ **Do you have any family history of problems with general anesthesia?**

☐ **Do you have latex allergies?**

☐ **Do you have betadine allergies?**

Social History

Occupation

_____

Marital Status

☐ Married ☐ Divorced

☐ Single ☐ Widowed

Tobacco Use

	Y	N		
Cigarettes	☐	☐	Y	Packs per day _____
Smokeless Tobacco	☐	☐		

Alcohol Use

Beer	☐	☐	Bottles per day _____
Wine	☐	☐	Glasses per day _____
Hard Liquor	☐	☐	Drinks per day _____

Family History

	Father	Mother	Sibling	Sibling	Sibling
Colon CA					
Breast CA					
Ovarian CA					
Prostate CA					
Hypertension					
Heart Attack					
High Cholesterol					
Diabetes					
Bleeding Disorder					

Please make note of any other family history issues:

_____

_____

_____

_____

_____

_____

Health Maintenance

Please note the approximate date and result of your most recent:

Complete Physical Exam: ☐ Never Result: _____

Month _____ Year _____

Cardiac Stress Test

Month _____ Year _____ ☐ Never Result: _____

Colonoscopy

Month _____ Year _____ ☐ Never Result: _____

Women

Mammogram

Month _____ Year _____ ☐ Never Result: _____

Pap Smear

Month _____ Year _____ ☐ Never Result: _____

Men

PSA

Month _____ Year _____ ☐ Never Result: _____