

HEALTH DATA BASE

Name _____ Age _____ Date _____

To properly care for you at the time of your surgery, we need a *complete* summary of your medical history.

PAST MEDICAL HISTORY:

Previous surgeries and serious illnesses:

Medical conditions currently being treated:

Current medications and dosages:

Family Doctor/Internist:

Drug Allergies:

FAMILY MEDICAL HISTORY: Circle status & list past/present illnesses.

Mother: Alive - Deceased

Father: Alive - Deceased

Maternal Grandparents: Alive - Deceased

Paternal Grandparents: Alive - Deceased

Siblings:

SOCIAL HISTORY:

Occupation: _____ How long? _____

City where you reside: _____ Married? _____

Persons with whom you live: _____

Spouse _____ Friend _____ Child _____ Live Alone _____

Dominant hand (*circle*): Right or Left

Tobacco use? Yes No Packs per day _____

Alcohol use? None Moderate Habitual

SYSTEMS REVIEW (circle)

General Health: Good Fair Poor

Weight Change last 6 months: Loss Gain total lbs. _____

Severe reaction to anesthesia: No Yes

Tendency to bleed excessively: No Yes

SYSTEMS REVIEW *continued*:

MD Notes

Central Nervous System & Psychiatric

Difficulty sleeping	No	Yes
Troubled by depression	No	Yes
Troubled by anxiety	No	Yes
Uncorrectable vision	No	Yes
Uncorrectable hearing	No	Yes
Severe headaches	No	Yes
Fainting spells	No	Yes
Seizures or convulsions	No	Yes

Respiratory & Cardiovascular

Cough	No	Yes
Shortness of breath	No	Yes
Chest pain	No	Yes
Palpitation/fluttering heart	No	Yes
High Blood pressure	No	Yes

Urinary & Gastrointestinal

Burning with urination	No	Yes
Frequent urination	No	Yes
Decreased urination force	No	Yes
Stomach pain or burning	No	Yes
Frequent loose stools	No	Yes
Frequent constipation	No	Yes

Musculoskeletal

Osteoarthritis	No	Yes
Rheumatoid arthritis	No	Yes
Gout	No	Yes
Back problems	No	Yes

Skin

Frequent rashes	No	Yes
Bruise easily	No	Yes
History of skin cancer	No	Yes

Endocrine

Excessive thirst	No	Yes
Excessive urination	No	Yes

HEENT

Difficulty swallowing	No	Yes
Ear drainage	No	Yes
Frequent earaches	No	Yes
Wear glasses or contacts	No	Yes
Double or blurry vision	No	Yes

Physical Exam Weight _____ B/P _____ Pulse _____

Abnormalities:

Patient signature: _____

MD Initials & Date				