

HC HIGHLAND CLINIC

SURGERY

PATIENT HISTORY FORM

PCP/REFERRING MD

DATE: _____

FAX TO 4451

Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Past Medical History:

Do you have?

- None
- Heart Disease
- Lung Disease
- Diabetes
- Osteoporosis
- Arthritis
- Fibromyalgia
- Thyroid Disease
- Other _____
- Cancer
- Depression
- Liver Disease
- Kidney Disease
- Asthma
- Gout
- Mitral Valve Prolapse
- High Blood Pressure

Past Surgical History:

Have you had?

- Thyroid
- Appendectomy
- Hysterectomy
- Wisdom Teeth
- Gallbladder
- Tonsillectomy
- Other _____
- None

Family History:

- High Blood Pressure
- Heart Disease
- Lung Disease
- Diabetes
- Bleeding Problems
- Other _____
- Cancer
- Depression
- Liver Disease
- Kidney Disease
- Rheumatologic Disease
- None

Social History:

- Occupation: _____
- Transfusion Yes No
- Tobacco Use Yes No _____ Pks/Day
- Alcohol Use Yes No
- Drug Use Yes No
- Marital Status _____

Allergies: NONE or list each allergy _____

Medications: Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc) None

Health Maintenance: Date of last

Pelvic/Pap _____ Mammogram _____ Rectal _____ PSA _____ Tetanus _____ Colonoscopy _____

Review of Systems: Do you have?

- Fatigue
- Chills
- Fever
- Weight Gain
- Weight loss
- Chest Pain
- Irregular Heartbeat
- Skin Rash
- Skin Lesion
- Chronic Headache
- Constipation
- Reflux
- Blood in stool
- Nausea/Vomiting
- Seizures
- Diarrhea
- Depression
- Bruising
- Cough
- Shortness of Breath
- Painful Urination
- Frequent Urination
- Asthma
- Blood in Urine
- Coughing up Blood
- Swollen/painful joints