WINDOM AREA HEALTH

GENERAL SURGERY PATIENT HISTORY FORM

Patient Name: ____DOB: __________ Age: __________ Date: ______________

Primary Healthcare Provider: ____

Describe your main problem: ____

Where is your problem located? ____

How long have you had this problem? ____

When does this problem occur? ____

Does anything make this problem better or worse? ____

Any associated signs/symptoms? ____

List previous hospitalizations/Surgeries/Serious injuries When

____ ____________
____ ____________
____ ____________
____ ____________
____ ____________

Current medications:

1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________
7. ________________________
8. ________________________
9. ________________________
10. ________________________

Marital Status: __Single___Married___Separated___Divorced___Widowed

Use of alcohol: ___Never___Rarely___Moderate___Daily

Use of tobacco: ___Never___ Previously___ Current packs/day_____

Use of Drugs: ___Never___ Previously___ Current type/frequency_____________

Medication Allergies: ____________
____
____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	________	______________________________	________________________
Mother	________	______________________________	________________________
Siblings	_______	______________________________	________________________
	________	______________________________	________________________
Spouse	________	______________________________	________________________
Children	________	______________________________	________________________
	________	______________________________	________________________

Other side ----------→

Medical History and Review of Systems_______________

Do you now have or have you had any problems related to the following body systems? Please explain any yes answers in the comments space provided below each section.

GENERAL SYMPTOMS

Fever	No	Yes
Chills	No	Yes
Weight loss	No	Yes
Malaise/Fatigue	No	Yes
Diaphoresis	No	Yes

Comments:____

SKIN

Rash	No	Yes
Itching	No	Yes
Change in skin color	No	Yes
Varicose veins	No	Yes

Comments:____

HENT

Hearing loss	No	Yes
Tinnitus	No	Yes
Ear pain	No	Yes
Ear discharge	No	Yes
Nosebleeds	No	Yes
Congestion	No	Yes
Sinus pain	No	Yes
Stridor	No	Yes
Sore throat	No	Yes

Comments:____

EYES

Blurred vision	No	Yes
Double vision	No	Yes
Photophobia	No	Yes
Eye Pain	No	Yes
Eye discharge	No	Yes
Eye redness	No	Yes

Comments:____

CARDIOVASCULAR

Chest pain	No	Yes
Palpitations	No	Yes
Troubles breathing when lying	No	Yes
Pain in legs	No	Yes
Leg swelling	No	Yes
Shortness of breath waking you from sleep	No	Yes
Stent placement	No	Yes
Fainting	No	Yes
Arrhythmia	No	Yes
Murmur	No	Yes
Hypertension	No	Yes
Stroke	No	Yes
Blood clot	No	Yes
Anemia	No	Yes

Comments:____

RESPIRATORY

Cough	No	Yes
Coughing up blood	No	Yes
Sputum production	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
Snoring	No	Yes

Comments:____

GASTROINTESTINAL

Heartburn	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Abdominal pain	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Dark stools	No	Yes
Hemorrhoids	No	Yes
Changes in bowel habits	No	Yes

Comments:____

GENITOURINARY

Painful urination	No	Yes
Urinary urgency	No	Yes
Urinary frequency	No	Yes
Blood in urine	No	Yes
Flank pain	No	Yes

MUSCULOSKELETAL

Muscle pain	No	Yes
Neck pain	No	Yes
Back pain	No	Yes
Joint pain	No	Yes
Falls	No	Yes

Comments:____

ENDOCRINE/HEME/ALLERGIC/IMMUNOLOGIC

Easily bruise or bleed	No	Yes
Environmental allergies	No	Yes
Excessive thirst	No	Yes

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics	No	Yes
Iodine or other antiseptic	No	Yes
Anesthetics	No	Yes
Morphine, Demerol, other narcotics	No	Yes
Latex	No	Yes

Comments:____

NEUROLOGICAL

Dizziness	No	Yes
Headaches	No	Yes
Tingling	No	Yes
Tremors	No	Yes
Sensory changes	No	Yes
Speech changes	No	Yes
Weakness	No	Yes
Seizures	No	Yes
Loss of consciousness	No	Yes

Comments:____

PSYCHIATRIC

Depression	No	Yes
Suicidal ideas	No	Yes
Substance abuse	No	Yes
Hallucinations	No	Yes
Nervous/anxious	No	Yes
Insomnia	No	Yes
Memory loss	No	Yes

Comments:____

BREAST

Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Comments:____