The Surgical Group of Southwest Michigan

PERSONAL HISTORY FORM

Name: ______________________________________ Birthdate: _________________

Age: ______________ Sex: M F Height: ______________
Weight: ______________

Occupation: ___________________________
Duties: ____

Describe in your own words why you are here

____
____
____

List all **MEDICAL ALLERGIES and REACTIONS**

____
____
____

List all **CURRENT MEDICATIONS** **DOSAGE**

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____
____
____
____
____
____
____
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____

List all **X-RAYS/TESTING** done for the current problem:

____
____
____
____
____

Name:________________________________ Birthdate:___________________

HISTORY OF MEDICAL CONDITION

Please circle Y or N for any of the following past or current conditions

Neurological

Seizures/Epilepsy	Y	N
Stroke	Y	N

Gastrointestinal

Gallbladder problems	Y	N
Stones	Y	N
Hiatal hernia	Y	N
Ulcers	Y	N
Hemorrhoids	Y	N

Genitourinary

Kidney stones	Y	N
Kidney infections	Y	N
Kidney failure	Y	N
Kidney dialysis	Y	N

Location: ______________________

Days: _________________________

Cardiovascular

Heart attack/year	Y	N
Irregular beat	Y	N
Pacemaker	Y	N
Defibrillator	Y	N
High blood pressure	Y	N
Congestive heart failure	Y	N

Respiratory

Asthma/Bronchitis	Y	N
Emphysema/COPD	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N
Shortness of breath?	Y	N
With stairs?	Y	N

Hematological

Anemia	Y	N
Blood clots	Y	N
Bleeding disorder	Y	N

What type? _____________________

Sickle cell anemia	Y	N
High cholesterol	Y	N

Musculoskeletal

Arthritis	Y	N
Spinal stenosis	Y	N
Carpal tunnel	Y	N

Vascular

Aneurysm	Y	N
Varicose veins	Y	N
Skin ulceration	Y	N
Phlebitis	Y	N

Arm or leg? ____________

Mental

Alzheimer's	Y	N
Depression	Y	N

Other

Diabetes	Y	N
Cancer	Y	N
Thyroid problems	Y	N
Hepatitis	Y	N

A B C

MRSA	Y	N

Have you ever been tested for HIV? Y N

Results: ______________________________

Are you on a special diet? Y N

What kind? ________________

Personal and Social History

Tobacco use: Never Current Former

Type of tobacco: ______________________

When did you quit? ______________ (MM/YY)

Used tobacco in the past year? ___________

Do you exercise? Y N

Do you drink alcohol? Y N

How much? ___________________

Name:________________________________ Birthdate:___________________

PAST SURGICAL HISTORY

Please circle Y or N for any of the following SURGERIES. If YES, please indicate year.

Appendectomy	Y	N	____	Hysterectomy/ovaries	Y	N	____
Arterial angioplasty	Y	N	____	Intestinal	Y	N	____
Arterial bypass	Y	N	____	Kidney surgery	Y	N	____
Balloon dilation (heart)	Y	N	____	Lung surgery	Y	N	____
Breast biopsy	Y	N	____	Mastectomy	Y	N	____
Carotid surgery	Y	N	____	Prostate surgery	Y	N	____
Cataract/eye surgery	Y	N	____	Stomach surgery	Y	N	____
Gallbladder surgery	Y	N	____	Thyroid surgery	Y	N	____
Heart bypass	Y	N	____	Tonsillectomy	Y	N	____
Hemorrhoids	Y	N	____	Vein stripping/ligation	Y	N	____
Hernia repair	Y	N	____	Other ____________________________			____

FAMILY HISTORY

Please circle Y or N for any FAMILY HISTORY. If YES, please indicate immediate family member.

Arterial disease	Y	N	Heart trouble	Y	N
Bleeding disorder	Y	N	Hypertension	Y	N
Breast cancer	Y	N	Lung disease	Y	N
Cancer	Y	N	Stroke	Y	N
Diabetes	Y	N	Varicose veins	Y	N

Other ____

REVIEW OF SYSTEMS

Please circle Y or N if you have had any of the following:

Neurological

Visual disturbance	Y	N
Dizziness	Y	N
Loss of balance	Y	N
Difficulty with speech	Y	N
Unusual memory loss	Y	N
Loss of strength	Y	N
Unusual headaches	Y	N

HEENT

Difficulty in swallowing	Y	N
Hard of hearing	Y	N
Eye/ear pain	Y	N

Musculoskeletal

Back pain	Y	N
Joint pain	Y	N
Numbness fingers/toes	Y	N
Tingling fingers/toes	Y	N

Vascular

Leg pain, cramping, weakness	Y	N
After walking or rest	Y	N
Change in color fingers/toes	Y	N
Change in color hands/feet	Y	N
Aching in hips	Y	N
Swelling in hands/feet	Y	N

Heart

Chest pain	Y	N
Rapid heartbeat	Y	N

Gastrointestinal

Poor appetite	Y	N
Indigestion/heartburn	Y	N
Abdominal pain	Y	N
Abdominal swelling	Y	N
Unusual diarrhea	Y	N
Unusual constipation	Y	N
Rectal bleeding	Y	N
Recent loss of weight	Y	N

Genitourinary

Pain/burning when urinating	Y	N
Blood in urine	Y	N
Difficulty controlling urine	Y	N
Difficulty having erections	Y	N
Breast lump	Y	N
Nipple discharge	Y	N

PATIENT SIGNATURE: ____________________________

DATE: ________________________

DATE: ________________________