MountainStar General Surgery

Health History Form

Name: _____ Date of birth: _____

Weight _____ Height_____ Age_____

Why are you seeing the Doctor today? _____

Referring Physician: _____

List any treatment or tests you have had for this problem: _____

_____

Medications

Medication/Vitamin	Dose/strength	Reason

Past Surgeries/ Year

_____

_____

_____

_____

Medical Conditions

_____

_____

_____

_____

Family History: **please indicate family members with any of the following conditions:**

Alcoholism _____

Cancer _____

Heart disease _____

Depression/suicide _____

Genetic disorders _____

Diabetes _____

Kidney disease _____

High cholesterol _____

High blood pressure _____

Stroke _____

Bleeding/clotting disorder _____

Asthma/COPD _____

Anxiety _____

Other _____

Allergies: **Do you have allergies or reactions to:**

Medications: _____Foods:_____

Do you use tobacco? **_Yes _No** Do you Drink Alcohol? **_Yes _No**

Do you use any recreational drugs? **_Yes _No**

Review of systems

Constitutional __Unexplained weight loss/gain __Recent fever/sweats __Unexplained fatigue/weakness __Recent chills/cold sweats ***Cardiology*** __Chest pain/discomfort __Palpitations __Decreased exercise tolerance ***Dermatology*** __Rash __New or change in mole ***Endocrinology*** __Cold/heat intolerance __Increase thirst/appetite ***ENT*** __Change in hearing __Congestion __Sinus Pain __Sore throat	***Hematology/Lymph*** __Unexplained lumps __Easy bruising/bleeding ***Genitourinary*** __Painful/bloody urination __Leaking urine __Nighttime urination __Discharge: Penis or vagina __Concern with sexual functions ***Gastroenterology*** __Heartburn/reflux __Bloody stools __Change in bowel movement __Nausea/vomiting/diarrhea __Pain in abdomen __Gas __Hemorrhoids ***Musculoskeletal*** __Muscle/joint pain __Recent back pain __Weakness __Swollen joints	***Neurology*** __Memory loss __Headaches __Fainting __Numbness/tingling in hand/feet __Loss of balance ***Ophthalmology*** __Change in vision __ Eye pain ***Psychology*** __Anxiety/stress __Sleep problems ***Respiratory*** __Cough/wheeze __Coughing blood __Shortness of breath __Pain with breathing ***Woman*** Last mammogram_____ __Breast lump/pain __Irregular periods Last menstrual cycle_____ Age of first menstruation _____

Signature: _____ Date: _____