

CHART # _____

Patient's Personal History

The following information is very important to your health. Please take the time to fully and accurately fill out this form. This form may be sent to a surgery center if surgery is ordered.

| | | | | | | | |
|---|---------------|---------------|-------------|---------------|-------------|--------------|------------------------|
| Name: Last First M.I. | | | Sex: | DOB: | Age: | Race: | Marital Status: |
| SSN: | Home#: | Cell#: | | Work#: | | | |
| Emergency Contact & Phone #: | | | | | | | |

Previous Surgeries:
 (Where, When, & Why)

Previous Injuries, & Hospitalizations:
 (Where, When, & Why)

Other Illnesses Not Hospitalized For:

Any Allergies (drug, food, latex, adhesives, etc.):

Present Medications:
 (Name & Dosage)

Personal Habits:

Do you smoke? Y N How much per day/week? _____

Do you drink caffinated beverages? Y N How much per day/week? _____

Do you drink alcohol? Y N How much per day/week? _____

Additional Information:

| | |
|--|---|
| Have you ever taken medicine for High Blood Pressure? Y N | Have you ever had an allergic reaction to latex? Y N |
| Had x-ray treatment to head or neck areas as a child? Y N | |
| Date of last EKG? _____ | |
| Date of last chest xray? _____ | |
| Date of last TB skin test? _____ | |

Review of Symptoms:

Have you had any of these symptoms within the last 6 months?

HEAD & NECK

visual disturbances Y N
 hearing or ear problems Y N
 frequent headaches Y N
 dizziness Y N
 asthma, "hay fever" Y N
 sinus troubles Y N
 frequent colds Y N
 painful swallowing Y N
 lump or swelling of neck Y N
 sore throat w/o cold Y N
 enlarged tonsils Y N
 problems with teeth Y N
 swelling of gums or jaw Y N
 tongue sore or sensitive Y N
 nosebleeds Y N

CHEST

stroke Y N
 heart attack/problems Y N
 pain in chest Y N
 chronic cough Y N
 vomited/ coughed blood Y N
 skipping or racing heart Y N

ABDOMINAL/ INTESTINAL

abdominal pain Y N

constipation Y N
 change in bowel stools Y N
 bloody/ black stools Y N
 jaundice Y N
 poor appetite Y N
 ulcers Y N
 rectal bleeding Y N

GENITO-URINARY

urinary infection Y N
 frequent urination during night Y N
 blood in urine Y N
 kidney stones Y N

BONES & JOINTS

cramps in legs Y N
 broken bones Y N
 swollen ankles Y N
 back trouble Y N
 arthritis Y N
 cyst or growth Y N

GENERAL SYMPTOMS

bleeding problems Y N
 numbness Y N
 convulsions/ seizures Y N
 unusual fatiguability Y N
 worry, depression Y N

insomnia Y N
 weight gain/ loss Y N
 nervous breakdown Y N
 fever or chills Y N
 night sweats Y N
 shortness of breath Y N

OTHER ILLNESSES

anesthesia problems Y N
 cancer Y N
 diabetes Y N
 high blood pressure Y N
 high cholesterol Y N
 other _____ Y N

*MEN ONLY

pain/ swelling in testicles Y N
 weak urine stream Y N
 prostate infection Y N

*WOMEN ONLY

hot flashes Y N
 urination when cough/ sneeze Y N
 lumps in breast Y N
 bleeding between periods Y N
 vaginal discharge Y N
 complications of pregnancy Y N

Family History:

Has anyone in your family (parents, grandparents, aunts/uncles, children) ever had...?

| | Y | N | WHO? | | Y | N | WHO? |
|----------------------------|---|---|-------|--------------------|---|---|-------|
| Anesthesia Problems | Y | N | _____ | Leukemia | Y | N | _____ |
| Arthritis | Y | N | _____ | Mental Illness | Y | N | _____ |
| Asthma, Hay Fever, Allergy | Y | N | _____ | Seizures/ Epilepsy | Y | N | _____ |
| Cancer | Y | N | _____ | Sickle Cell Anemia | Y | N | _____ |
| Diabetes | Y | N | _____ | Stroke | Y | N | _____ |
| Glaucoma | Y | N | _____ | Thyroid Disorders | Y | N | _____ |
| Heart Attack/ Problems | Y | N | _____ | Tuberculosis | Y | N | _____ |
| High Blood Pressure | Y | N | _____ | Ulcers | Y | N | _____ |
| High Cholesterol | Y | N | _____ | Other: | Y | N | _____ |
| Kidney Stones | Y | N | _____ | | Y | N | _____ |

***WOMEN ONLY:**

of children? _____
 Date of last menstrual period? _____
 Last PAP smear? _____
 Method of birth control? _____
 Have you ever aborted or had problems with pregnancy or deliveries? _____

Completed by: Patient Other: _____ Relationship to Patient: _____

I attest that the above information is true and correct to the best of my knowledge.

Date: _____ Patient Signature: _____

Updated on: _____ Patient Signature: _____

(may be used as reattestation if surgery is less than 1 year later)