

**PATIENT PERSONAL HISTORY FORM  
GENERAL SURGERY**

Please take time to update the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.

<b>NAME</b>	<b>BIRTHDATE</b>	<b>DATE</b>
<b>CHIEF COMPLAINTS: (Please list current symptoms)</b>		
<b>1.</b>	<b>3.</b>	
<b>2.</b>	<b>4.</b>	

<b>PAST MEDICAL HISTORY: Hospitalizations and Surgeries</b>			
Reason/Diagnosis/Procedure	Date	Reason/Diagnosis/Procedure	Date

<b>MEDICAL ILLNESSES OR CONDITIONS: (Conditions you now have or have had in the past.)</b>					
Condition	Onset Date	Condition	Onset Date	Condition	Onset Date
<input type="checkbox"/> Migraine headaches	_____	<input type="checkbox"/> Stomach or duodenal ulcer	_____	<input type="checkbox"/> Goiter	_____
<input type="checkbox"/> Seizures or convulsions	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Gonorrhea	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Cirrhosis	_____	<input type="checkbox"/> Syphilis or VD	_____
<input type="checkbox"/> Polio	_____	<input type="checkbox"/> Gall stones	_____	<input type="checkbox"/> HIV infection	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Colon or bowel trouble	_____	<input type="checkbox"/> Herpes infection	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Dysentery or serious diarrhea	_____	<input type="checkbox"/> Chicken pox	_____
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Rectal trouble	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Recurrent ear infections	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Deafness	_____	<input type="checkbox"/> Recurrent urinary infections	_____	<input type="checkbox"/> Recurrent boils	_____
<input type="checkbox"/> Hay fever, allergic nose	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Skin problems	_____
<input type="checkbox"/> Recurrent sinusitis	_____	<input type="checkbox"/> Other kidney disease	_____	<input type="checkbox"/> Serious depression	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Serious emotional problems	_____
<input type="checkbox"/> Chronic bronchitis	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Nervous breakdown	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Broken bones	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Varicose veins	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Heart murmur	_____	<input type="checkbox"/> Phlebitis or blood clots	_____	<i>Women</i>	
<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Bleeding problems	_____	<input type="checkbox"/> Menstrual difficulties	
<input type="checkbox"/> Angina	_____	<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Abnormal PAP	
<input type="checkbox"/> Enlarged heart	_____	<input type="checkbox"/> Cancer (Type: _____)	_____	<input type="checkbox"/> Ovarian cyst(s)	
<input type="checkbox"/> Rheumatic fever	_____	<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Breast lump(s)	
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Overactive thyroid	_____	<i>Men</i>	
<input type="checkbox"/> Hiatal hernia / chronic heartburn	_____	<input type="checkbox"/> Underactive thyroid	_____	<input type="checkbox"/> Prostate trouble	

<b>CURRENT MEDICATIONS: (Include non-prescription products)</b>		<b>ALLERGIES: (Include drugs foods, chemicals, insects, etc.)</b>	
Drug Name	Dose	Item	Type of Reaction

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<b>IMMUNIZATIONS &amp; PREVENTIVE SERVICES: (Check all that apply and provide date you last received each.)</b>					
<input type="checkbox"/> MMR	_____	<input type="checkbox"/> TB skin test	_____	<input type="checkbox"/> PAP smear	_____
<input type="checkbox"/> Tetanus	_____	<input type="checkbox"/> Hearing test	_____	<input type="checkbox"/> Mammogram	_____
<input type="checkbox"/> Pneumonia vaccine	_____	<input type="checkbox"/> Eye exam	_____	<input type="checkbox"/> Bone density test	_____
<input type="checkbox"/> Hepatitis B vaccine	_____	<input type="checkbox"/> Sigmoid or colon exam	_____	<input type="checkbox"/> PSA	_____

<b>FAMILY HISTORY: Please complete the following information on your relatives.</b>				
	Living	Dead	Age	Chronic condition(s)/Cause of Death
Father				
Mother				
Brothers (No. _____) & Sisters (No. _____)				
Spouse				
Children (No. _____)				

<b>Please check all conditions identified in your relatives and note which relatives are affected:</b>					
Condition	Relation	Condition	Relation	Condition	Relation
<input type="checkbox"/> Migraine headaches	_____	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Bleeding problems	_____
<input type="checkbox"/> Seizures or convulsions	_____	<input type="checkbox"/> Stomach or duodenal ulcer	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Sickle cell disease	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Gall stones	_____	<input type="checkbox"/> Cancer, including leukemia	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Colon or bowel trouble	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Thyroid problems	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Other kidney disease	_____	<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Suicide	_____
<input type="checkbox"/> Heart trouble	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Birth defects	_____

<b>SOCIAL/PERSONAL HISTORY: Please complete the following information about yourself.</b>	
Current occupation: _____	
Education completed:	
<input type="checkbox"/> Grade: _____ <input type="checkbox"/> High School <input type="checkbox"/> College: _____ years, degree/major _____ <input type="checkbox"/> Post-graduate: _____	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married (Date: _____) <input type="checkbox"/> Separated (Date: _____) <input type="checkbox"/> Divorce (Date: _____)	
Married _____ time(s): #1 _____ yrs, _____ children #2 _____ yrs, _____ children #3 _____ yrs, _____ children	
Personal habits: (check all that apply)	
<input type="checkbox"/> Currently uses tobacco: Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless tobacco Amount/day: _____ Years: _____	
<input type="checkbox"/> Former smoker: Amount/day: _____ Years: _____ Quit Date: _____	
<input type="checkbox"/> Exposed to second-hand smoke	
<input type="checkbox"/> Consume alcohol: Type: _____ Amount/day: _____	
<input type="checkbox"/> Use recreational drugs: Type: _____ Amount/day: _____	
<input type="checkbox"/> Consume caffeine: Beverage: _____ Amount/day: _____	
<input type="checkbox"/> Exercise regularly: Type: _____ Frequency/week: _____	
<input type="checkbox"/> Wear my seatbelt: Frequency (%): _____	
Sexual history: <input type="checkbox"/> Multiple sex partners <input type="checkbox"/> Prefer opposite sex <input type="checkbox"/> Prefer same-sex relationships	

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**Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>REVIEW OF SYSTEMS: (Please check any item which describes recent or ongoing symptoms)</b>	
<b>General:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Significant weight loss <input type="checkbox"/> Loss of feeling of well-being <input type="checkbox"/> Fatigue or loss of energy <input type="checkbox"/> Difficulty sleeping Comment: _____	
<b>Eyes:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Spots in front of your eyes <input type="checkbox"/> Eye pain/irritation <input type="checkbox"/> Need for corrective lenses Comment: _____	
<b>Ear-Nose-Throat:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Chronic headaches <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Dizziness <input type="checkbox"/> Chronic nasal congestion <input type="checkbox"/> Recurring sinus infections <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Sore throat <input type="checkbox"/> Toothache <input type="checkbox"/> Breath odor <input type="checkbox"/> Hoarseness Comment: _____	
<b>Respiratory:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Chest congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Choking <input type="checkbox"/> Noisy breathing <input type="checkbox"/> History of pneumonia <input type="checkbox"/> History of Tuberculosis (TB) Comment: _____	
<b>Cardiovascular:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Chest pain <input type="checkbox"/> Heart fluttering/racing <input type="checkbox"/> Heart murmur <input type="checkbox"/> Decreased exercise tolerance <input type="checkbox"/> Awakened due to shortness of breath <input type="checkbox"/> Difficulty breathing while lying down <input type="checkbox"/> Leg swelling <input type="checkbox"/> Pain in buttocks or legs with exercise <input type="checkbox"/> Sensitivity of hands/feet to temperature changes Comment: _____	
<b>Breast :</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Breast lump <input type="checkbox"/> Breast pain <input type="checkbox"/> Nipple discharge Comment: _____	
<b>Gastrointestinal :</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Stomach pains <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Frequent heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Belching/sour taste <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Bloating <input type="checkbox"/> History of hepatitis <input type="checkbox"/> History of yellow jaundice <b>Rectal:</b> <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Rectal pain or irritation <input type="checkbox"/> Swelling or hemorrhoids Comment: _____	
<b>Genitourinary (Men):</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Frequent urination ( <input type="checkbox"/> often at night) <input type="checkbox"/> Frequent urge to pee <input type="checkbox"/> Pain on urination <input type="checkbox"/> Bloody urine <input type="checkbox"/> Discharge from penis <input type="checkbox"/> Trouble starting urination <input type="checkbox"/> Interruption of urine stream <input type="checkbox"/> Dribbling <input type="checkbox"/> Loss of bladder control <input type="checkbox"/> Pain or swelling of penis <input type="checkbox"/> Pain or swelling of scrotal sac <input type="checkbox"/> Pain or swelling in groin <input type="checkbox"/> Decline in sexual desire <input type="checkbox"/> Difficulty having erections or reaching climax Comment: _____	

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<b>Genitourinary (Women):</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Frequent urination ( <input type="checkbox"/> often at night) <input type="checkbox"/> Frequent urge to pee <input type="checkbox"/> Pain on urination <input type="checkbox"/> Bloody urine <input type="checkbox"/> Frequent urinary infections <input type="checkbox"/> Pressure in vagina <input type="checkbox"/> Vaginal wall weakness/protrusion <input type="checkbox"/> Frequent loss of urine <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal irritation <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Vaginal redness <input type="checkbox"/> Vaginal pain <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Decline in sexual desire <input type="checkbox"/> Difficulty in sexual response <input type="checkbox"/> Hot flashes <input type="checkbox"/> Change in periods (menstrual flow, frequency) <input type="checkbox"/> Mother took DES while pregnant with me <input type="checkbox"/> Painful periods <input type="checkbox"/> Troublesome symptoms before/during period <input type="checkbox"/> Other pelvic pain <i>Please indicate:</i> Number of pregnancies _____   Number of deliveries _____   Number of miscarriages/abortions _____ Age of onset of periods _____   Periods occur every _____ of days and last _____ days   Onset of last period _____ Comment: _____	
<b>Lymphatic/Hematologic:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Unusual lymph node swelling (in neck, armpit, or groin) <input type="checkbox"/> Painful lymph nodes <input type="checkbox"/> History of anemia <input type="checkbox"/> Blood clots <input type="checkbox"/> Bruise easily <input type="checkbox"/> Unusual bleeding Comment: _____	
<b>Musculoskeletal:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Limb or joint pains <input type="checkbox"/> Limb or joint deformity <input type="checkbox"/> Limb or joint swelling/stiffness/redness <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Loss of muscle bulk <input type="checkbox"/> Muscle spasms or twitching <input type="checkbox"/> Recurring back/neck pain <input type="checkbox"/> Back/neck injury Comment: _____	
<b>Neurologic:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Seizures <input type="checkbox"/> Tremors/shakiness <input type="checkbox"/> Unusual clumsiness <input type="checkbox"/> Limb weakness <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Stroke <input type="checkbox"/> History of significant head injury <input type="checkbox"/> Altered consciousness or black-outs Comment: _____	
<b>Psychologic:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Lapses in memory <input type="checkbox"/> Periods of confusion/disorientation <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Troublesome depression <input type="checkbox"/> Worry about things <input type="checkbox"/> Mood swings <input type="checkbox"/> History of mental illness <input type="checkbox"/> Unusual stress <input type="checkbox"/> History of physical or mental abuse Comment: _____	
<b>Skin:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Unusual dryness <input type="checkbox"/> Changes in hair <input type="checkbox"/> Changes in pigmentation Comment: _____	
<b>Endocrine:</b>	<input type="checkbox"/> <i>None apply</i>
Unexpected changes in: <input type="checkbox"/> Tolerance to heat <input type="checkbox"/> Tolerance to cold <input type="checkbox"/> Unusual thirst Comment: _____	
<b>Allergy/Immunologic:</b>	<input type="checkbox"/> <i>None apply</i>
<input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Sensitivity to specific items: _____ <input type="checkbox"/> Frequent or unusual infections Comment: _____	