Name: _____ **Patient Medical History**

Date of Birth:_____Height: _____ Weight: _____ **Consultants in General Surgery**

Patient Referred by: _____ Reason for Referral: _____

Past Medical History: Please list any medical problems you have:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Surgical History/ Trauma History: List the operations or injuries you have had, along with the month, year and Hospital

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you or any family members ever had a reaction to anesthesia? _____ Bleeding Problems? _____

Medications: List the medications you are currently taking along with the dosages, include nonprescription items such as St. John's Wort, dietary supplements, diet pills, cold and flu medications, etc.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____9. _____

Have you taken the following in the last month? Prednisone_____ Coumadin_____ Aspirin/ Motrin/ Naprosyn _____

What meds are you ALLERGIC to? _____

Review of Systems: Check the appropriate box if you have had these symptoms recently

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Fevers	___	___	Calf Pain	___	___	Upper Abdominal Pain	___	___	Nipple discharge
___	___	Night Sweats	___	___	Short of breath	___	___	Lower Abdominal Pain	___	___	Headache or migraines
___	___	Fatigue	___	___	SOB with exertion	___	___	Yellow Jaundice	___	___	Dizziness
___	___	Weight changes	___	___	SOB at night	___	___	Painful urination	___	___	Room spinning
___	___	Vision changes	___	___	Irregular Pulse	___	___	Blood in urine	___	___	Seizures
___	___	Double vision	___	___	Wheezing	___	___	Straining on urination	___	___	Passing out
___	___	Hearing loss	___	___	Cough, ?sputum	___	___	Kidney stones	___	___	Numbness or tingling
___	___	Ringing in ears	___	___	Coughing blood	___	___	Pelvic pain	___	___	Memory loss
___	___	Ear pain or drainage	___	___	Diarrhea	___	___	Vaginal discharge/bleeding	___	___	Anxiety
___	___	Bloody nose	___	___	Constipation	___	___	Joint or muscle pain	___	___	Depression
___	___	Nasal discharge	___	___	Stool incontinence	___	___	Decreased mobility, weakness	___	___	Suicidal thoughts
___	___	Sinusitis	___	___	Black tary stools	___	___	Joint swelling	___	___	Excessive hair growth
___	___	Sore throat	___	___	Bloody stools	___	___	Skin rash	___	___	Excessive thirst
___	___	Hoarseness	___	___	Difficulty swallowing	___	___	Itching	___	___	Excessive urination
___	___	Oral ulcers	___	___	Heartburn	___	___	Mole changes	___	___	Easy bruising
___	___	Chest pain	___	___	Nausea	___	___	Loss of hair	___	___	Bleeding tendency
___	___	Palpitations	___	___	Vomiting	___	___	Difficulty w/ nails	___	___	Swollen nodes
___	___	Ankle swelling	___	___	Vomiting blood	___	___	Breast lumps, pain			

Menstrual History: Age of onset _____ Age of Menopause _____ Number of Pregnancies _____ Live births _____

Miscarriages _____ Last menstrual period _____ Age of first pregnancy _____ Do you take birth control pills? _____

Social History: Marital status: _____ Number of children _____ International travel? _____

Occupation: _____ Do you do heavy lifting on a daily basis? _____

Cigarette Smoking: I have smoked _____ packs per day for _____ years. Quit smoking in _____ Drug use? _____

Please describe your alcohol intake: _____None____ Occasional ____ 1-2 drinks per day _____ >2 drinks per day

Family History: Check the box if you have first degree relatives with the following cancers or diseases:

Breast Ca ___ Ovarian Ca ___ Colon Ca ___ Skin Ca ___ Lymphoma ___ Leukemia ___ Inflammatory bowel disease ____

Brain tumors ___ Heart disease ___ Thyroid disease ___ Parathyroid disease ___ Other _____

Reviewed by: _____ Date: _____