SOUTHERN SURGICAL MEDICAL HISTORY QUESTIONNAIRE

Full Name:_____

Name you prefer to be called:_____

List any DRUG ALLERGIES (if none, write none) _____

_____

List your current medications and how taken (prescription and over the counter medications, herbs, vitamins, etc.). Example: Name, strength, prescribing physician, and dosage re: once, twice a day

_____

_____

_____

Medical Conditions: Have you ever been diagnosed with any of the following:

Diabetes	High blood pressure	Heart disease	High cholesterol
Stroke	Anemia	Asthma	Lung disease
Arthritis	Cancer	HIV (AIDS)	Kidney disease
Liver disease	Migraines	Stomach ulcers	Thyroid disease
Psychiatric illness		Blood clots	Pulmonary embolus

Other illnesses:_____

Personal Surgical History: Indicate whether you have had any of the following surgeries with dates:

Coronary artery bypass graft (open heart surgery)_____
Cholecystectomy (gallbladder removed_____
Appendectomy(appendix removed)_____
Hysterectomy (some/all female reproductive organs removed)_____
Tonsillectomy (Adenoidectomy/tonsil/adenoids removed)_____
Colectomy (part of bowel removed)_____
Joint replacement_____
Stents in vessels_____
Hernia repair_____
Colonoscopy/EGD_____
Other_____

Social History:
Do you smoke: _____yes _____packs per day _____no
If you quit, how long did you smoke? _____years
Do you drink alcohol? _____yes _____no
Do you dip or chew tobacco? _____yes _____no
Occupation_____Church_____(optional)

Over----------

Please check all symptoms which you have presently or have had recently.
If you have not experienced a medical problem under the SYMPTOMS listed,
Check the "NO" box.

GENERAL SYMPTOM
_____fever _____weight loss _____weight gain
_____No General Symptoms

EAR, NOSE, &THROAT SYMPTOMS
_____hearing loss _____sore throat
_____nasal congestion
_____No Ear, Nose, & Throat Symptoms

EYE SYMPTOMS
_____blindness _____blurred vision
_____double vision _____loss of vision
_____No Eye Symptoms

HEART SYMPTOMS
_____leg cramps while sleeping
_____blackout spells
_____trouble breathing while lying flat
_____No Heart Symptoms

LUNG SYMPTOMS
_____wheezing _____shortness of breath
_____No Lung Symptoms

GASTROINTESTINAL SYMPTOMS
_____heartburn _____frequent diarrhea
_____No Gastrointestinal Symptoms

KIDNEY SYMPTOMS
_____difficulty urinating
_____ frequent urination
_____ No Kidney Symptoms

BONE, JOINT, & MUSCLE SYMPTOMS
_____ joint pain _____ joint swelling
_____No Bone, Joint, or Muscle Symptoms

SKIN SYMPTOMS
_____ lesion _____masses
_____No Skin Symptoms

NERVOUS SYSTEM SYMPTOMS
_____convulsions
_____seizures
_____No Nervous System Symptoms

BLOOD (HEMATOLOGIC SYMPTOMS)
_____swollen lymph nodes
_____bruising without contact
_____bleeding tendency
_____No Blood (Hematologic) Symptoms

ENDOCRINE SYMPTOMS
_____excessive thirst
_____heat intolerance
_____cold intolerance
_____No Endocrine Symptoms

ALLERGIES
_____hay fever _____ food allergies

PSYCHIATRIC

_____emotional disturbances
_____No Psychiatric Illnesses

FOR OFFICE USE ONLY

HGT:

WGT:

TEMP:

HR:

BP:

PATIENT PLEASE FILL OUT THE FOLLOWING:

SOUTHERN SURGICAL FAMILY HISTORY QUESTIONAIRE

NAME:_____

EMAIL:_____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT RUN IN THE FAMILY:

MOTHER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

FATHER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

SISTER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

BROTHER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

DAUGHTER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYE_____

SON: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

MATERNAL GRANDMOTHER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

MATERNAL GRANDFATHER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

PATERNAL GRANDMOTHER: DIABETES HIGH BLOOD PRESSURE HEART DISEASE CANCER/TYPE_____

PATERNAL GRANDFATHER: DIABETES HIGH BLOOD PRESSURE HEART DIEASE CANCER/TYPE_____