

# Plainview Surgical Care

## HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

Birthdate \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

**History of present illness:**

**Location:** \_\_\_\_\_

(Where is the pain/problem?)

**Severity:** \_\_\_\_\_

(How severe is the pain on a scale of 1-5 with 5 being the most severe?)

**Timing:** \_\_\_\_\_

(Does the pain/problem occur at a specific time?)

**Associated signs/symptoms :** \_\_\_\_\_

(What other associated problems have you been having?)

**Quality:** \_\_\_\_\_

(Example: pain is sharp, crampy, dull; blood is bright red, dark, etc.)

**Duration:** \_\_\_\_\_

(How long have you had this pain/problem?, When did it start?)

**Context:** \_\_\_\_\_

(Where were you at the onset of this pain/problem?)

**Modifying factors :** \_\_\_\_\_

(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

**Past Medical History**

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Anemia . . . . . no yes	Bladder Infections . . . . . no yes	Back Trouble . . . . . no yes	Thyroid Disease . . . . . no yes
Blood or Plasma	Kidney Disease . . . . . no yes	Epilepsy/Seizures . . . . . no yes	Constipation . . . . . no yes
Transfusion . . . . . no yes	Diabetes . . . . . no yes	Migraine Headaches . . . . . no yes	Diarrhea . . . . . no yes
Bleeding Tendency . . . . . no yes	Glaucoma . . . . . no yes	Bronchitis . . . . . no yes	Hemorrhoids . . . . . no yes
High Blood Pressure . . . . . no yes	Cancer . . . . . no yes	Asthma . . . . . no yes	Ulcer . . . . . no yes
Low Blood Pressure . . . . . no yes	Polio . . . . . no yes	Tuberculosis . . . . . no yes	Date of last colonoscopy _____
Hepatitis . . . . . no yes	Heart Disease . . . . . no yes	Arthritis . . . . . no yes	Any other diseases: _____
Hives or Eczema . . . . . no yes	Mitral Valve Prolapse . . . . . no yes	Hernia . . . . . no yes	_____
Stroke . . . . . no yes	AIDS/HIV+ . . . . . no yes	Infectious Mono . . . . . no yes	_____

**Previous Surgeries/Serious Illnesses**

**When**

**What Hospital**


**Patient Social History**

Marital status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_  
 Use of alcohol: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_  
 Use of tobacco: Never: \_\_\_\_\_ Previously – Quit: \_\_\_\_\_ Current packs/day: \_\_\_\_\_  
 Use of drugs: Never: \_\_\_\_\_ Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

**Female Medical History**

Age at first period: \_\_\_\_\_ Number of Children \_\_\_\_\_ Age at birth of first child: \_\_\_\_\_  
 Age at Menopause: \_\_\_\_\_ Hormone replacement therapy? \_\_\_\_\_  
 Previous breast biopsy or lump? \_\_\_\_\_

**Family Medical History**

	Age	Diseases	If deceased, cause of death
<b>Father</b>	_____	_____	_____
<b>Mother</b>	_____	_____	_____
<b>Siblings</b>	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

\_\_\_\_\_  
Initial of Reviewing Doctor/Date