General Surgery Health History Questionnaire:

FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Name____ Date of birth______________________________

Address____

Local phone number_____________________________ Alternative phone number__________________

Please describe what problem or concern brought you to our office today:

____

Details of Chief Complaint:	
How long has this been going on?	
Please rate your pain, circle one: 1 2 3 4 5 6 7 8 9 10	
Is the problem on the Right Side? ☐ Y ☐ N	Is the problem on the Left Side? ☐ Y ☐ N
What makes the symptoms better?	
What makes the symptoms worse?	
What test(s) have you had recently in relation to your problem?	

Personal Health History		**Previous Surgical Procedures**	
Please check past(P) or current(C) problems or conditions		Procedure	Year
P☐ C☐ Hypertension	P☐ C☐ Osteoporosis/ Osteopenia	☐ Heart surgery	
P☐ C☐ High cholesterol		☐ Carotid artery surgery	
P☐ C☐ Diabetes	P☐ C☐ Bowel/digestive problem	☐ Vascular surgery / stent	
P☐ C☐ Heart attack or angina	P☐ C☐ Seizures	☐ Abdominal aneurysm repair	
P☐ C☐ Irregular heart rhythm	P☐ C☐ Headaches	☐ Intestinal surgery	
P☐ C☐ Congestive heart failure	P☐ C☐ Stroke	☐ Hysterectomy	
P☐ C☐ Asthma	P☐ C☐ Prostate problem	☐ Pacemaker/Cardiac Defibrillator	
P☐ C☐ Emphysema or chronic bronchitis	P☐ C☐ Breast problem	☐ Gallbladder removed	
	P☐ C☐ Urinary tract infections	☐ Appendix removed	
P☐ C☐ Pneumonia	P☐ C☐ Arthritis	☐ Joint replacement	
P☐ C☐ Gastroesophageal reflux disease	P☐ C☐ Thyroid problem	☐ Hip ☐ Right ☐ Left	
	P☐ C☐ Bleeding disorder	☐ Knee ☐ Right ☐ Left	
P☐ C☐ Atrial Fibrillation	P☐ C☐ Addiction Issues	☐ Spine Surgery ☐ Neck ☐ Back	
P☐ C☐ Kidney Disease, Type:	P☐ C☐ Depression	☐ Breast cancer surgery	
P☐ C☐ Liver Disease, Type:	P☐ C☐ Anxiety	☐ Prostate cancer surgery	
P☐ C☐ Cancer, Type:	P☐ C☐ Mental Illness	☐ Hernia	
P☐ C☐ Stomach ulcer	P☐ C☐ Other:	☐ Other: ______________________	

Social History:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Live here year round? ☐ Yes ☐ No If no, Part time location: ____
Occupation: **Concerns**: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting
Tobacco use: ☐ Never ☐ Quit (when)____________ ☐ Current smoker: Packs/day, how many years______________________
Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often________________
Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often________________
Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current Describe:____

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headaches, frequent	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Hemorrhoids	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period____________
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies _________
☐ Vomiting	☐ Arms ☐ Hips	☐ Back	Miscarriages__________________
☐ Vomiting blood	☐ Legs ☐ Neck	☐ Shoulders	Birth control method ___________
☐ Change in bowel habits	☐ Hands ☐ Feet	☐ Abdomen	Menopause ☐ Y ☐ N Age: ________

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Hypertension	
☐ Cancer, Type: ____________________		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations		Last Occurrence	Tests		Last Occurrence
Tetanus vaccine / Tdap	☐ Yes ☐ No		Mammogram	☐ Yes ☐ No	
Pneumonia vaccine	☐ Yes ☐ No		Ultrasound	☐ Yes ☐ No	
Influenza vaccine	☐ Yes ☐ No		CT Scan	☐ Yes ☐ No	
Shingles vaccine	☐ Yes ☐ No		MRI	☐ Yes ☐ No	
Hepatitis ☐ A ☐ B	☐ Yes ☐ No		PET Scan	☐ Yes ☐ No	
Guardasil (HPV)	☐ Yes ☐ No		Colonoscopy	☐ Yes ☐ No	
			Chest X-Ray	☐ Yes ☐ No	
			Pap smear/pelvic	☐ Yes ☐ No	
			Bone Density	☐ Yes ☐ No	
			Prostate test	☐ Yes ☐ No	

Hospital Admissions (excluding pregnancies)

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: ________________________________ **Phone**: ____________________ **Store #**: _____________________

Location Description: ____

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice	
Primary Care Name: ______________________________ Phone: __________________ Last Seen:__________	**Nephrologist** Name: ______________________________ Phone: __________________ Last Seen: __________
Cardiologist Name: ______________________________ Phone: __________________ Last Seen:__________	**Gynecologist** Name: ______________________________ Phone: __________________ Last Seen: __________
Oncologist Name: ______________________________ Phone: __________________ Last Seen:__________	**Allergist** Name: ______________________________ Phone: __________________ Last Seen: __________
Urologist Name: ______________________________ Phone: __________________ Last Seen:__________	**Psychiatrist/Psychologist** Name: ______________________________ Phone: __________________ Last Seen: __________
Gastroenterologist Name: ______________________________ Phone: __________________ Last Seen:__________	**Pulmonologist** Name: ______________________________ Phone: __________________ Last Seen: __________
Endocrinologist Name: ______________________________ Phone: __________________ Last Seen:__________	**Podiatrist:** ______________ Name: ______________________________ Phone: __________________ Last Seen: __________
Ophthalmologist Name: ______________________________ Phone: __________________ Last Seen:__________	**Other:** ______________ Name: ______________________________ Phone: __________________ Last Seen: __________

Patient/Guardian Signature:______________________________________ Date:________________