FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

General Surgery
Health History Questionnaire

Name ______________________________ **Date of Birth** ____/____/______

Details of Chief Complaint	
Please describe what problem brought you to our office today :	
Location of symptoms : ☐ Right Side ☐ Left Side	How long has this been going on ?
Please rate your pain level on a scale of 0 (no pain) to 10 (worst pain possible) :	
What tests have you had recently in relation to your problem?	
What makes your symptoms better ?	What makes your symtoms worse?

Current Health Concerns Please check problems or conditions that you are CURRENTLY experiencing				
☐ Chest pain/discomfort	☐ Abdominal pain	☐ Weight loss (lbs. _______)	☐ Loss of vision	☐ Insomnia
☐ Shortness of breath	☐ Heartburn	☐ Weight gain (lbs. _______)	☐ Double vision	☐ Depression
☐ Wheezing	☐ Indigestion	☐ Loss of appetite	☐ Memory lapses or loss	☐ Nervousness
☐ Cough	☐ Ankle swelling	☐ Difficulty swallowing	☐ Ringing in ears	☐ Pain in testicles
☐ Coughing up blood	☐ Nausea	☐ Painful urination	☐ Pain in ears	☐ Loss of libido
☐ Sore throat	☐ Vomiting	☐ Blood in urine	☐ Nose bleeds	☐ Impotence
☐ Nasal congestion	☐ Vomiting blood	☐ Urine frequency	☐ Hoarseness	☐ Breast pain
☐ Irregular heartbeat	☐ Change in bowel habits	☐ Decrease in urine flow	☐ Easy bleeding	☐ Breast discharge
☐ Fast heartbeat	☐ Rectal bleeding	☐ Urine leakage	☐ Easy bruising	☐ Other:
☐ High blood pressure	☐ Black/tarry stools	☐ Headaches, frequent	☐ Rash	
☐ Low blood pressure	☐ Hemorrhoids	☐ Loss of strength	☐ Changes in a mole	
☐ Lightheadedness	☐ Diarrhea	☐ Balance problems	☐ Sore that won't heal	
☐ Dizziness/fainting	☐ Constipation	☐ Eye pain	☐ Fatigue/lethargy	

Pain, weakness, or numbness in:

☐ Arms ☐ Hips ☐ Lower Back ☐ Legs ☐ Neck ☐ Shoulders ☐ Hands ☐ Feet ☐ Abdomen

Females - Please complete

Menstrual flow: ☐ Regular ☐ Irregular ☐ Pain/cramps ☐ Pain or bleeding after sex Menopause ☐ Y ☐ N Age: ________

1st day of last period: ________________ Birth control method : ________________________

Number of pregnancies: ______________ Number of Miscarriages: ________________________

Health Maintenance

Tests	Month	Year	Tests	Month	Year
Pap Smear/HPV Screening			Colonsocopy/Cologuard		
Mammogram			Chest X-ray		
Bone Density (DEXA)			Prostate-Specific Antigen (PSA)		
			Low Dose Lung CT		

Patient/Guardian Signature: ________________________________ Date: ________________

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