The Surgical Group of Southwest Michigan

PERSONAL HISTORY FORM

Name: ______________________________________ Birthdate: ________________

Age: _____________ Sex: M F Height: _____________

Weight: _____________

Occupation:______________________Duties:_________________________________

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Describe in your words why you are here:

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List all MEDICAL ALLERGIES and REACTIONS

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List all CURRENT MEDICATIONS **DOSAGE**

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List all X-RAYS / TESTING done for the current problem:

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History of Medical Condition

Please circle Y or N for any of the following past or current conditions

Neurological

Seizures/Epilepsy	Y	N
Stroke	Y	N

Gastrointestinal

Gall bladder problems	Y	N
Stones	Y	N
Hiatal Hernia	Y	N
Ulcers	Y	N
Hemorrhoids	Y	N

Genitourinary

Kidney stones	Y	N
Kidney infections	Y	N
Kidney failure	Y	N
Kidney dialysis	Y	N

Location ______________________

Days ______________________

Cardiovascular

Heart attack / year	Y	N
Irregular beat	Y	N
Pacemaker	Y	N
Defibrillator	Y	N
High blood pressure	Y	N
Congestive heart failure	Y	N

Respiratory

Asthma / Bronchitis	Y	N
Emphysema / COPD	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N

Hematological

Anemia	Y	N
Blood clots	Y	N
Bleeding Disorder	Y	N

What type ______________________

Sickle cell anemia	Y	N
High cholesterol	Y	N

Musculoskeletal

Arthritis	Y	N
Spinal stenosis	Y	N
Carpal tunnel	Y	N

Vascular

Aneurysm	Y	N
Varicose Veins	Y	N
Skin ulceration	Y	N
Phlebitis	Y	N

Arm or leg ________________

Mental

Alzheimer's	Y	N
Depression	Y	N

Other

Diabetes	Y	N
Cancer	Y	N
Thyroid problems	Y	N
Hepatitis	Y	N

A B C

MRSA	Y	N

Have you ever been tested for HIV Y N

Results______________________________

Are you on a special diet Y N

What kind ________________

Personal and Social History

Do you smoke	Y	N
How many years	________________	
How many per day	________________	
Did you quit	________________	
Do you exercise	Y	N
Do you drink alcohol	Y	N
How much	________________	

PAST SURGICAL HISTORY

Please circle Y or N for any of the following surgeries / if answering Y indicate year

Surgery			Year
Appendectomy	Y	N	_____
Arterial Angioplasty	Y	N	_____
Arterial bypass	Y	N	_____
Balloon dilation (heart)	Y	N	_____
Breast biopsy	Y	N	_____
Carotid surgery	Y	N	_____
Cataract / eye surgery	Y	N	_____
Gallbladder surgery	Y	N	_____
Heart bypass	Y	N	_____
Hemorrhoids	Y	N	_____
Hernia Repair	Y	N	_____
Hysterectomy / ovaries	Y	N	_____
Intestinal	Y	N	_____
Kidney surgery	Y	N	_____
Lung surgery	Y	N	_____
Mastectomy	Y	N	_____
Prostate surgery	Y	N	_____
Stomach surgery	Y	N	_____
Thyroid surgery	Y	N	_____
Tonsillectomy	Y	N	_____
Vein Stripping / ligation	Y	N	_____
Other______________________________			_____

Family History / Indicate immediate family member/Please circle Y or N

Condition		
Arterial disease	Y	N
Bleeding disorder	Y	N
Breast cancer	Y	N
Cancer	Y	N
Diabetes	Y	N
Heart trouble	Y	N
Hypertension	Y	N
Lung disease	Y	N
Stroke	Y	N
Varicose Veins	Y	N

Other____

Review of Systems / Please circle Y or N if you have had any of the following

Neurological

Visual disturbance	Y	N
Dizziness	Y	N
Loss of Balance	Y	N
Difficulty with speech	Y	N
Unusual memory loss	Y	N
Loss of strength	Y	N
Unusual headaches	Y	N

HEENT

Difficulty in swallowing	Y	N
hard of hearing	Y	N
Eye / ear pain	Y	N

Musculoskeletal

Back pain	Y	N
Joint pain	Y	N
Numbness fingers/toes	Y	N
Tingling fingers/toes	Y	N

Vascular

Leg pain, cramping or weakness	Y	N
After walking or rest	Y	N
Change in color; finger / toes	Y	N
Change in color; hands / feet	Y	N
Aching in hips	Y	N
Swelling in hands/feet	Y	N

Heart

Chest pain	Y	N
Rapid heart beat	Y	N

Gastrointestinal

Poor appetite	Y	N
Indigestion / heart burn	Y	N
Abdominal pain	Y	N
Abdominal swelling	Y	N
Unusual diarrhea	Y	N
Unusual constipation	Y	N
Rectal bleeding	Y	N
Recent loss of weight	Y	N

Genitourinary

Pain/burning when urinating	Y	N
Blood in urine	Y	N
Difficulty controlling urine	Y	N
Difficulty having erections	Y	N
Breast lump	Y	N
Nipple discharge	Y	N

PATIENT SIGNATURE:

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DATE: ________________________

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