

Council Bluffs Surgical Associates, P.C.

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HEALTH HISTORY

Confidential

Patient Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: M F Date of last physical exam: _____

Marital Status: Single Married Widowed Divorced Separated

What is the reason for your visit? _____

Primary Physician: _____ Referring Physician: _____

REVIEW SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats
- Weight gain
- None

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders
- None

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination
- None

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Food Intolerances (greasy, fried)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Swallowing problems
- Vomiting
- Vomiting blood
- None

CARDIOVASCULAR

- Chest pain
- Heart attack
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins
- None

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Sore throat
- Sores in mouth or throat
- Vision-Flashes
- Vision-Halos
- None

SKIN

- Bruise easily
- Change in moles
- Hives
- Itching
- Rash
- Scars
- Sore that won't heal
- None

MEN ONLY

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other
- None

WOMEN ONLY

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Menopause
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other
- None

Date of last menstrual period: _____

Date of last Pap Smear: _____

Date of last mammogram: _____

Do you use birth control? _____

Have you been hit, slapped, kicked or otherwise physically injured by someone? Yes No

If Yes, explain: _____

Any other symptoms not listed: _____

CONDITIONS: Check (✓) conditions you have or have had in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> DVT | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> PE | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem | |

Any other conditions not listed: _____

CURRENT MEDICATIONS (Include prescription, over-the-counter and herbals):

NAME OF MEDICINE	DOSE	HOW OFTEN TAKEN	REASON FOR TAKING	LENGTH OF TIME TAKEN

ALLERGIES: List any allergies you have to Medications, foods or environment: _____

Do you have a **LATEX** sensitivity or allergy? Yes No
 Following a medical, surgical or dental procedure, have you ever had any unexplained itching, hives, swelling or anaphylactic reaction? Yes No
 Have you had symptoms such as sneezing, coughing, rash or hives when handling rubber products, balloons, latex gloves or Band-Aid's? Yes No

Please complete the TABLE below for any PRIOR cancer, radiation, treatment, or chemotherapy that you may have had:					
	Don't know	No	Yes	Year	Kind of cancer or Type of disease / condition
Prior Cancers:					
Prior Radiation Treatment (not dental x-rays or for broken bones):					
Prior Chemotherapy:					

FAMILY HISTORY:

Are you Adopted? Yes No Are you a Twin? Yes No What type of twin? Identical Fraternal Don't know
 Excluding yourself, how many of each of the following blood-related family members do you have? **Remember to include those who are no longer living.**
 Include only **full** brothers or sisters. Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

FAMILY HISTORY – Fill in health information about your immediate family.				
Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Grandparents				

Check (✓) if your blood relatives had any of the following:	
Disease	Relationship to you
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Anemia	
<input type="checkbox"/> Arthritis, Gout	
<input type="checkbox"/> Asthma, Hay Fever	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease, Strokes	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Malignant Hyperthermia	
<input type="checkbox"/> Tuberculosis	

HOSPITALIZATIONS/SURGERIES			PREGNANCY HISTORY	
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Complications (if any)

Have you had any reaction to anesthesia? Yes No
 Do you take any anticoagulants (*i.e. Aspirin, Coumadin, Plavix*) ? If so, please list: _____
 Do you have a pacemaker, defibrillator or stent of any kind If so, please list: _____
 Have you ever had a chest x-ray? Yes No Date: _____
 Flu Vaccine? Yes No Date: _____ Pneumovax? Yes No Date: _____
 Tetanus? Yes No Date: _____
 Do you use seat belts? Yes No If you have children do you use a car safety seat? Yes No

Are you pregnant? Yes No
HEALTH HABITS: Check (✓) which substances you use and describe how much you use.
 Caffeine
 Tobacco
 Street Drugs
 Alcohol
 Other

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME	OCCUPATIONAL CONCERNS: Check (✓) if your work exposes you to the following:
			<input type="checkbox"/> Stress
			<input type="checkbox"/> Hazardous Substances
			<input type="checkbox"/> Heavy Lifting
			<input type="checkbox"/> Other
			Your occupation: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Relationship to Patient _____