PRESIDIO
surgical group, pc

Patient History Form

Name (Last, First, Initial): _____ Birthdate: _____ ☐ Male ☐ Female

Marital Status (check one): ☐ Single ☐ Divorced ☐ Married ☐ Widowed Who lives with you? _____

Employer: _____ Occupation: _____ Type of Work _____

Primary Care Physician: _____ Other Doctors involved with your care: _____

REVIEW OF SYSTEMS

Have you or the patient ever been diagnosed with any of the following? If yes, please check **Yes** or **No** and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? ☐ No ☐ Yes

Gastrointestinal

Diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Rectal bleeding	☐ No	☐ Yes
Change in BMs	☐ No	☐ Yes
Weight loss	☐ No	☐ Yes
Polyps	☐ No	☐ Yes
Irritable Bowel	☐ No	☐ Yes
Crohn's Disease	☐ No	☐ Yes
Ulcerative Colitis	☐ No	☐ Yes
Trouble swallowing	☐ No	☐ Yes
Nausea/Vomiting	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Abdominal Pain	☐ No	☐ Yes

Hepatic

Liver Disease	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes
Pancreatitis	☐ No	☐ Yes

Cardiac

High blood pressure	☐ No	☐ Yes
Low blood pressure	☐ No	☐ Yes
Irregular heartbeat	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes

Respiratory

Asthma	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes
Bronchitis	☐ No	☐ Yes
Chronic Cough	☐ No	☐ Yes
Hoarseness	☐ No	☐ Yes
Tracheostomy	☐ No	☐ Yes

Genitourinary

Kidney Disease	☐ No	☐ Yes
Frequent urine infection	☐ No	☐ Yes

Endocrine/Metabolic

Diabetes	☐ No	☐ Yes
Thyroid Disorders	☐ No	☐ Yes

Neurologic

Seizures	☐ No	☐ Yes
Previous stroke	☐ No	☐ Yes

Musculoskeletal

Muscle Disease	☐ No	☐ Yes
Neck pain	☐ No	☐ Yes
Back pain	☐ No	☐ Yes

Skin

Rash	☐ No	☐ Yes
Bruises	☐ No	☐ Yes

Ophthalmic

Cataracts	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Blindness	☐ No	☐ Yes

Ear, Nose & Throat

Nosebleeds	☐ No	☐ Yes
Deafness	☐ No	☐ Yes

Vascular

Leg Ulcers	☐ No	☐ Yes
Vericose Veins	☐ No	☐ Yes
Amputations	☐ No	☐ Yes

Breast

Lumps	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Fibrocystic Disease	☐ No	☐ Yes

Psychosocial

Alcoholism	☐ No	☐ Yes
Substance Abuse	☐ No	☐ Yes
Depression/Anxiety	☐ No	☐ Yes

Explanation:

_____

_____

_____

_____

_____

_____

PAST HISTORY

Please explain any YES answers in detail in the boxes provided.

Have you ever had surgery or been hospitalized? ☐ No ☐ Yes

I've had surgery for	Dates	I've been hospitalized for	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any problems with anesthesia? ☐ No ☐ Yes

If you answered "Yes" please list the anesthesias:

_____

_____

_____

Are you currently, or have you ever used tobacco? ☐ No ☐ Yes

If you answered "Yes" please fill in information below:

I smoke or used to smoke _____ cigarettes per day. I have been smoking for, or used to smoke for _____ years.

Do you use or have you ever used alcohol? ☐ No ☐ Yes

If you answered "Yes" please fill in information below:

I drank/drink _____ alcoholic beverages per day. I have been drinking or used to drink for _____ years.

Are you using or have you ever used recreational/illicit drugs? ☐ No ☐ Yes

If you answered "Yes" please fill in information below:

I use, or used to use, _____ for _____ years.

I use, or used to use, _____ for _____ years.

I use, or used to use, _____ for _____ years.

I use, or used to use, _____ for _____ years.

Do you take medications or drugs (including over-the-counter, prescription, birth control pills? ☐ No ☐ Yes

If you answered "Yes" please fill in information below:

I take this dose _____ of this medication _____ this many times/day _____

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I take this dose _____ of this medication _____ this many times/day _____

Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion? ☐ No ☐ Yes

FAMILY HISTORY

Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	No/Yes	Relation to Patient
Colon/Rectal Cancer	☐ No ☐ Yes	_____
Stomach Cancer	☐ No ☐ Yes	_____
Breast Cancer	☐ No ☐ Yes	_____
Kidney Problems	☐ No ☐ Yes	_____
Ulcerative Colitis	☐ No ☐ Yes	_____
Ovarian Cancer	☐ No ☐ Yes	_____
Heart Disease	☐ No ☐ Yes	_____
Crohn's Disease	☐ No ☐ Yes	_____
Bleeding Problems	☐ No ☐ Yes	_____

ADDITIONAL MEDICATIONS

Please list any additional medications not listed above.

Do you take medications or drugs (including over-the-counter, prescription, birth control pills? ☐ No ☐ Yes

If you answered "Yes" please fill in information below:

I take this dose _____ of this medication _____ this many times/day _____

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