SURGICAL CONSULT SERVICES
PATIENT HISTORY QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____

AGE: _____ **GENDER:** ☐ **MALE** ☐ **FEMALE**

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOW** ☐ **OTHER** _____

OCCUPATION: _____

REASON(S) FOR VISIT:

_____

_____

_____

WHEN DID SYMPTOMS START? _____

_____

ALLERGIES TO MEDICATIONS:

NAME OF MEDICATION	REACTION TO MEDICATION

PHARMACY

Name: Phone Number:

Location:

CURRENT MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY	REASON

NAME: _____ **DATE OF BIRTH:** _____

MEDICAL HISTORY

DATE OF DIAGNOSIS	MEDICAL CONDITION

COLONOSCOPY HISTORY

COLONOSCOPY DATE	PERFORMING PHYSICIAN

SURGICAL HISTORY Pacemaker: ☐ Yes ☐ No

SURGERY DATE	SURGERY

SOCIAL HISTORY:

TOBACCO USE

DO YOU SMOKE?
- ☐ NEVER SMOKED
- ☐ I SMOKE _____ PACKS/DAY
- ☐ I QUIT SMOKING IN _____

TYPE:
- ☐ CIGARETTE
- ☐ CIGAR
- ☐ PIPE
- ☐ CHEWING TOBACCO

ALCOHOL USE

DO YOU DRINK ALCOHOL?
- ☐ I NEVER DRINK ALCOHOL
- ☐ I HAVE _____ DRINKS PER WEEK.

TYPE:
- ☐ WINE
- ☐ LIQUOR
- ☐ BEER

NAME: _____ **DATE OF BIRTH:** _____

SOCIAL HISTORY CONTINUED:

DRUG USE

- ☐ PAST RECREATIONAL DRUG USE _____
- ☐ PRESENT RECREATIONAL DRUG USE _____
- ☐ NONE

SEXUALLY ACTIVE

- ☐ YES — PARTNERS: ☐ FEMALE ☐ MALE
- ☐ NO
- ☐ NOT CURRENTLY

FAMILY HISTORY:

DO ANY OF YOUR FAMILY MEMBERS HAVE:

PLEASE SPECIFY WHICH FAMILY MEMBER AND WHICH SIDE (MATERNAL / PATERNAL) IE: MOTHER'S SIDE OR FATHER'S SIDE

- ☐ ASTHMA _____
- ☐ BLEEDING DISORDER _____
- ☐ CANCER (WHAT TYPE?) _____
- ☐ CROHN'S DISEASE _____
- ☐ DIVERTICULITIS _____
- ☐ DEPRESSION _____
- ☐ DIABETES _____
- ☐ EMPHYSEMA _____
- ☐ HEART DISEASE _____
- ☐ HIGH CHOLESTEROL _____
- ☐ HYPERTENSION _____
- ☐ LIVER DISEASE _____
- ☐ ULCERATIVE COLITIS _____
- ☐ OTHER? _____

REVIEW OF SYSTEMS (CHECK ONLY POSITIVE ITEMS)

GENERAL:

- ☐ FEVER
- ☐ CHILLS
- ☐ UNEXPECTED CHANGE IN WEIGHT

HENT

- ☐ NOSEBLEEDS
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ NECK STIFFNESS
- ☐ TROUBLE SWALLOWING

EYES

- ☐ EYE PAIN
- ☐ VISUAL DISTURBANCES

RESPIRATORY

- ☐ APNEA
- ☐ CHOKING
- ☐ STRIDOR

NAME: _____ **DATE OF BIRTH:** _____

CARDIOVASCULAR

- ☐ CHEST PAINS
- ☐ PALPITATIONS
- ☐ DYSPNEA ON EXERTION
- ☐ SOB AT REST
- ☐ EDEMA

GASTROINTESTINAL:

NUMBER OF BOWEL MOVEMENTS PER DAY? _____

- ☐ NAUSEA
- ☐ VOMITTING
- ☐ ABDOMINAL PAIN
- ☐ BLOOD IN STOOL
- ☐ ABDOMINAL DISTENSION

ENDOCRINE

- ☐ POLYDIPSIA
- ☐ POLYPHAGIA
- ☐ POLYURIA
- ☐ HOT OR COLD INTOLERANCE

GENITOURINARY:

- ☐ FREQUENT URINATION
- ☐ URGENCY
- ☐ PAIN OR BURNING WITH URINATION
- ☐ BLOOD IN URINE
- ☐ FLANK PAIN

MUSCULOSKETETAL

- ☐ MUSCLE PAIN
- ☐ JOINT PAIN
- ☐ BONE PAIN

SKIN

- ☐ RASH
- ☐ LESIONS

ALLERGIC/IMMUNOLOGIC

- ☐ IMMUNOCOMPROMISED STATE

NEUROLOGICAL

- ☐ SEIZURES
- ☐ SYNCOPE
- ☐ TIA OR STROKE

HEMATOLOGIC

- ☐ ADENOPATHY
- ☐ BLEEDING DISORDERS

PSYCHIATRIC/BEHAVIORAL

- ☐ HALLUCINATIONS
- ☐ CONFUSION
- ☐ AGITATION

GYNECOLOGIC:

- ☐ PELVIC PAIN
- ☐ INFERTILITY
- ☐ ABNORMAL MENSTRUAL FLOW
- ☐ IRREGULAR MENSTRUAL FLOW
- ☐ OTHER

NAME: _____ **DATE OF BIRTH:** _____

PREGNANCY:

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____

HOW MANY CHILDREN DO YOU HAVE? _____

	1ST PREGNANCY	2ND PREGNANCY	3RD PREGNANCY
WHAT TYPE OF DELIVERY?	C-SECTION VAGINAL	C-SECTION VAGINAL	C-SECTION VAGINAL
COMPLICATIONS WITH PREGNANCY?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
COMPLICATIONS WITH DELIVERY?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
LENGTH OF LABOR	_____ HOURS	_____ HOURS	_____ HOURS
EPISIOTOMY?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
WEIGHT OF BABY?	POUNDS	POUNDS	POUNDS

PLEASE LIST ANY COMMENTS FOR PHYSICIAN:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT'S SIGNATURE _____

DATE: _____