William Newton
SURGERY SPECIALTIES

HEALTH HISTORY FORM

General Information

Name: _____ DOB: _____ Date:_____
Primary Care Physician: _____ Referring Physician: _____
Cardiologist: _____ Any other physicians you are seeing :_____
Preferred Pharmacy: _____ _____

☐ I am a new patient ☐ I am a returning patient. Last visit: _____

What are we seeing you for today? _____
How long have your symptoms been present? (if applicable) _____

Medical History

- ☐ Abnormal heart rhythm
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Barrett's esophagus
- ☐ Bipolar disorder
- ☐ Bleeding/clotting disorder
- ☐ Cancer (type) _____
- ☐ Carotid artery disease
- ☐ Cataracts
- ☐ Chest pain
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Crohn's disease/ulcerative colitis
- ☐ Degenerative disk disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Diverticulosis/diverticulitis (circle)
- ☐ Emphysema
- ☐ Enlarged prostate (BPH)
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gallbladder disease
- ☐ Gastritis/duodenitis (please circle)
- ☐ GERD (acid reflux)
- ☐ Glaucoma
- ☐ Gout
- ☐ H. Pylori
- ☐ Hearing loss
- ☐ Heart attack (MI)
- ☐ Heart disease (CAD)
- ☐ Heart valve problems
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Inflammatory bowel disease
- ☐ Intestinal problems
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Macular degeneration
- ☐ Mental illness
- ☐ Migraine/headaches
- ☐ Multiple Sclerosis
- ☐ Open wounds
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peripheral vascular disease
- ☐ Peptic ulcer disease
- ☐ Pneumonia
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sexually transmitted disease
- ☐ Sleep apnea
- ☐ Stomach ulcers
- ☐ Stroke/TIA
- ☐ Tuberculosis
- ☐ Other _____

Surgical History

- ☐ AAA repair
- ☐ Arthroscopy
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery (weight loss)
- ☐ Breast
- ☐ Cardiac surgery (bypass/stent/valve)
- ☐ Carotid endarterectomy
- ☐ Carpal tunnel release
- ☐ Cesarean section
- ☐ Cologuard (result/date) _____
- ☐ Colon/intestinal
- ☐ Colonoscopy (date)_____
- ☐ Defibrillator
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart cath (date) _____
- ☐ Hernia repair (type & date) _____
- ☐ Hip replacement (left or right?)
- ☐ Hysterectomy
- ☐ Knee replacement (left or right?)
- ☐ Mammogram (date) _____
- ☐ Neck surgery
- ☐ Orthopaedic surgery
- ☐ Pace maker
- ☐ Pap smear (date) _____
- ☐ Prostate surgery
- ☐ Sinus surgery
- ☐ Skin cancer excision
- ☐ Spine surgery
- ☐ Thyroid surgery
- ☐ Tonsillectomy
- ☐ Upper endoscopy (date) _____
- ☐ Vasectomy
- ☐ Other surgeries:

_____
_____
_____

Social History

Tobacco Use: ☐ Never ☐ Current/Former Smoker (quit date ___) ☐ Chewing Tobacco ☐ E-cigs ☐ Other _____
Alcohol: ☐ Never ☐ Occasional ☐ Daily (#drinks/day) ☐ History of alcohol abuse
Drug Use: ☐ Never ☐ History of drug abuse (type) _____ ☐ Current drug use (type) _____
Caffiene Use: ☐ Never ☐ Occasional ☐ Daily (#drinks/day) _____

Medications (name and dosage)

Immunization

Influenza - Date _____
Tetanus & Diptheria - Date _____
Pneumococcal (Prevnar 13 or Pneumovax) - Date _____
Zoster - Date _____

Allergies

Please list with reaction: _____
_____
_____

Any previous issues with anesthesia: ☐ No ☐ Yes (please explain): _____

Family History

☐ I do not know my family history
☐ Family history of issues with anesthesia

Mother ☐ Alive ☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Cancer (type) _____	☐ Other _____
Father ☐ Alive ☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Cancer (type) _____	☐ Other _____
Sister(s) #_____ ☐ Alive ☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Cancer (type) _____	☐ Other _____
Brother(s) #_____ ☐ Alive ☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Cancer (type) _____	☐ Other _____

STOP Review of Systems (below to be completed by provider)

General History:
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fatigue

Ear/Nose/Throat:
- ☐ Hoarseness
- ☐ Choking
- ☐ Sinus drainage
- ☐ Sore throat

Neurologic:
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Memory loss

Respiratory:
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Cough
- ☐ Recent infection

Cardiac:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swollen feet
- ☐ Last stress test _____

Gastrointesinal
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Rectal bleeding/dark stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in size of stools
- ☐ Pain or bulge at a scar
- ☐ Pain or bulge in the groin
- ☐ Upper or right sided abdominal pain

Breast (Female):
- ☐ Breast mass
- ☐ Nipple discharge
- ☐ Breast pain
- ☐ Date of mammogram _____

OB/GYN (Female):
- ☐ Date of last period: _____
- ☐ Age of menstruation: _____
- ☐ Age of menopause: _____

Genitourinary:
- ☐ Difficulty urinating
- ☐ Urinating frequently
- ☐ Blood in urine
- ☐ Incontinence

Endocrine:
- ☐ Hormone problem
- ☐ Excessive thirst/urination
- ☐ Heat or cold intolerance
- ☐ Neck mass

Hematologic:
- ☐ Slow wound healing
- ☐ Easy bruising or bleeding
- ☐ Anemia
- ☐ Enlarged glands
- ☐ Varicose veins

Dermatologic:
- ☐ Recent change in moles
- ☐ Rashes
- ☐ Masses below the skin
- ☐ Lesions that bleed
- ☐ Lesions that don't heal
- ☐ Skin tags
- ☐ Itchy skin lesion