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FOOTHILLS SURGICAL ASSOCIATES

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Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

TO GIVE YOU THE BEST POSSIBLE MEDICAL TREATMENT AND CARE, WE MUST OBTAIN A COMPLETE MEDICAL HISTORY. ANSWERING THIS QUESTIONNAIRE WILL ASSIST YOUR SURGEON.

Referring Physician: _____

Primary Care Physician/Provider: _____

Have you been seen in our office before? NO YES Date: _____

Have any family members been seen in this office? NO YES

Date: _____ Name _____ Relationship _____

Reason: _____ Surgeon Seen: _____

List of other Doctors you are seeing and why: _____

REASON FOR THIS VISIT

What is the reason for this visit? _____

Where is the problem (Location and right or left, if applicable)? _____

When did the problem start? _____

What are the symptoms? _____

When do the symptoms occur? _____

How long do the symptoms last? _____

How severe? _____

What relieves the symptoms? _____

Have you had any diagnostic tests (blood tests, x-rays, procedures) for the present problem? _____

When was your last Check Up/ Physical? _____

ANY ADDITIONAL INFORMATION: _____

DO YOU HAVE A LATEX ALLERGY? YES NO

DO YOU TAKE ANY BLOOD THINNERS? YES NO

ASPIRIN ADVIL/ANTI-INFLAMMATORY MEDS COUMADIN Other : _____

SUPPLEMENTS YOU TAKE: Garlic Ginseng Ginkgobiloba Vitamin E

DO YOU TAKE ANY WEIGHT REDUCING MEDICATION? YES NO

Phen/Fen Redux Fastin Other: _____

HAVE YOU (OR SOMEONE IN YOUR FAMILY) EVER HAD A REACTION TO ANESTHESIA AFTER SURGERY?

YES NO

Describe Reaction: _____

ALCOHOL USE: Do You Drink? YES NO

Never Occasional Daily #Drinks Per Week: _____

TOBACCO USE: Do You Smoke? YES NO

Of Packs Per Day _____ For How Many Years? _____

Date Quit: _____

Do You Chew Tobacco? YES NO

RECREATIONAL DRUG USE: Do You Use? YES NO

Which Drugs? _____ How Often? _____

HAS ANYONE IN YOUR FAMILY EVER HAD:

Diabetes YES NO Relationship to Patient _____

Heart Disease YES NO Relationship to Patient _____

Bleeding Problems YES NO Relationship to Patient _____

Cancer YES NO Relationship to Patient _____

Type: _____

High Blood Pressure YES NO Relationship to Patient _____

Other: _____ YES NO Relationship to Patient _____

FAMILY HEALTH HISTORY (Give type of illnesses or cause of death)

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Children _____

MARITAL STATUS: Single Married Separated Divorced Widowed

Last school grade completed: _____

Number of Children: _____

LIVING SITUATION:

House Apartment Assisted Living/Nursing Home Other _____

Occupation: _____ **Retired?** YES NO

Hobbies/Activities/Interests: _____

REVIEW OF SYSTEMS (Check only those that apply to you):

GENERAL:

Have you had any problems? YES NO
Weight Loss – How Much? _____
Weight Gain – How Much? _____
Fever _____
Night Sweats _____
Chills _____
Fatigue _____

EYES:

Have you had any problems? YES NO
Glasses/Contacts _____
Recent Vision Changes _____
Blindness _____
Cataract(s) _____
Glaucoma _____

HEAD AND MOUTH:

Have you had any problems? YES NO
Earaches _____
Hearing Loss _____
Hearing Aid _____
Sinus Problems _____
Frequent Head Colds _____
Dental Problems _____
Dentures _____
Bridges/Plates _____
Sores in Mouth _____
Throat Tenderness _____
Hoarseness _____
Swallowing Problems _____
Infections _____

CARDIOVASCULAR:

Have you had any problems? YES NO
Chest Pain _____
Palpitations _____
Arrhythmia _____
Heart Attack _____
Stroke _____
Coronary Artery Disease _____
Hypertension _____
Hypotension _____
Rheumatic Fever/Valvular Problem _____
Murmur _____
Congestive Heart Failure _____
Pulmonary Embolism _____
Thrombophlebitis/Blood Clots _____
Feet Swelling _____
Varicose Veins _____

RESPIRATORY:

Have you had any problems: YES NO
Shortness of Breath _____
Emphysema _____
COPD _____
Oxygen Requirement L per min _____
Cough/Bronchitis _____
Cough up Blood _____
Pneumonia _____
Asthma _____

DIGESTIVE:

Have you had any problems? YES NO
Abdominal Pain _____
Loss of Appetite _____
Nausea _____
Vomiting _____
Reflux/Heartburn _____
Ulcers _____
Indigestion _____
Diarrhea _____
Colitis _____
Constipation _____
Blood in Stool _____
Black/Tarry Stool _____
Hepatitis _____
Cirrhosis _____
Diverticulitis _____
Irritable Bowel Syndrome _____
Pancreatitis _____
Rectal Bleeding/Rectal Pain _____
Change in Bowel Habits _____
Hemorrhoids _____

URINARY:

Have you had any problems? YES NO
Frequent Urination _____
Hesitancy _____
Pain/Burning on urination _____
Blood in urine _____
Urinary Infections _____
Kidney Stone(s) _____
Kidney Failure _____

BREAST:

Have you had any problems? YES NO
Breast Lump(s) Right _____ Left _____
Lumpectomy Right _____ Left _____
Breast Tenderness Right _____ Left _____
Nipple Discharge Right _____ Left _____
Implants Date _____
Biopsy(ies) Right _____ Left _____
Mastectomy Right _____ Left _____
Breast Cyst(s) Right _____ Left _____
Fibrocystic Disease Right _____ Left _____

Last Mammogram: _____

FEMALE:

Have you had any problems? YES NO
Bleeding Between Periods _____
Painful Intercourse _____
Vaginal Discharge _____
Postmenopausal Bleeding _____
Last Menstrual Periods: _____
Onset of Menopause: _____
Number of Live Births _____
Number of Miscarriages _____
Age at First Period: _____
Last Pap _____
Number of Pregnancies _____
Number of Abortions _____

Wheezing _____
MALE:
Have you had any problems? YES NO
Inability to maintain erection _____
Vasectomy _____
Enlarged Prostate _____
Removal of Testicle Right _____ Left _____
Prostatectomy _____
Number of times up to urinate at night _____

EXTREMITIES/BACK:

Have you had any problems? YES NO
Arthritis _____
Gout _____
Back Pain _____
Muscle Weakness _____
Muscle Cramps _____
Injuries/Fractures _____

SKIN:

Have you had any problems? YES NO
Changes in Moles _____
Bleeding Mole or Lesion _____
Rash _____
Wounds _____
Skin Infections _____

NEUROLOGIC:

Have you had any problems? YES NO
Dizziness _____
Fainting _____
Headaches _____
Seizures _____
Paralysis _____
Head Injury _____

PSYCHIATRIC: (Emotional)

Have you had any problems? YES NO
Depression _____
Changes in Sleep Patterns _____
Memory Loss _____
Nervousness _____
Anxiety _____
History of Psychiatric Treatment _____

ENDOCRINE:

Have you had any problems? YES NO
Diabetes _____
Thyroid Problems _____
Goiter _____

BLOOD/LYMPHATIC:

Have you had any problems? YES NO
Anemia _____
Easy Bruising or Bleeding _____
History of Transfusions _____
Clotting Problems _____
Swollen Lymph Nodes _____
Jaundice _____
DVT/Phlebitis _____
Lupus _____

IMMUNOLOGIC/INFECTIONS:

Have you had any problems? YES NO
History of High Risk Sexual Activities _____
History of IV Drug Use _____
Tuberculosis _____

MY MEDICAL HISTORY QUESTIONNAIRE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Date: _____

Signed: _____
(Parent or Guardian)

I HAVE REVIEWED THIS MEDICAL HISTORY WITH THE PATIENT.

Date: _____

Signed: _____
(R.N., L.P.N., M.A.)

Signed: _____
(M.D.)

MEDICAL HISTORY REVIEWED WITHIN 6 MONTHS OF LAST VISIT.

Date: _____

Patient Initials: _____

Reviewed by: _____
(R.N., L.P.N., M.A. Initials)

M.D. Initials: _____

Date: _____

Patient Initials: _____

Reviewed by: _____
(R.N., L.P.N., M.A. Initials)

M.D. Initials: _____

