Winchester Surgical Clinic Patient History Form

Date completed_____

Patient Name: Last: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Social Security #: _____

REFERRAL INFORMATION

Requesting Physician: _____ _____Family Physician: _____

Preferred Pharmacy: _____Pharmacy Phone: _____

Reason for this visit:

_____

_____

Office Use Only:

VITALS	Height	Weight	B/P	Pulse

MEDICATION HISTORY

Allergies Yes ____ No ____ What to: _____

_____

Medications:

Current Medications			
NAME	**DOSAGE**	**HOW OFTEN?**	**WHY?**

PATIENT DEMOGRAPHICS

Review of Systems: Please circle all responses that apply to today's visit:

Constitutional:	**Fever** **Sweats**	**Weight loss/gain**	**Fatigue**	**Night sweats**
Ears, Nose, Throat:	**Mouth sores** **Voice change** **Hoarseness**	**Hearing loss/ringing** **Bleeding gums** **Swollen glands in neck**	**Earaches/drainage** **Bad breath/taste** **Chronic sinus problems**	**Nose bleeds** **Sore throat** **Snoring**
Respiratory:	**Cough** **Spitting/coughing up blood**	**Asthma** **Tuberculosis**	**Wheezing** **Pneumonia**	**Shortness of breath**
Cardiovascular:	**Calf pain** **Palpitations**	**Rapid heart beat** **Swelling of Feet/ankles/hands**	**Chest pain/angina** **Pacemaker**	**Heart murmur**
Gastrointestinal:	**Ulcers** **Rectal bleeding** **Difficulty Swallowing**	**Nausea** **Change in bowel habits** **Jaundice** **Gall bladder problems**	**Vomiting** **Painful bowel movements** **Abdominal Pain**	**Heartburn** **Diarrhea** **Constipation** **Appetite loss**
Genitourinary:	**Difficult urination** **Incontinence/Dribbling**	**Impotence** **Testicular Pain**	**Menstrual pain** **Kidney stones**	**Frequent urination** **Bloody urine**
Musculoskeletal:	**Bone pain weakness** **Joint Pain**	**Muscle Pain** **Back Pain**	**Leg Pain** **Stiffness**	**Difficulty walking** **Swelling**
Integumentary: (Skin, Breast)	**Change in Hair/Nails** **Skin Cancer** **Varicose veins**	**Rashes** **Unusual looking lesions** **Breast pain**	**Itching** **Ulcers** **Breast lump**	**Changes in skin color** **Easy bruising** **Nipple discharge**
Neurological:	**Tremors** **Tingling/numbness** **Meningitis**	**Dizziness** **Migraines/headaches** **Memory loss**	**Seizures** **Head injury** **Paralysis**	**Stroke** **Fainting**
Psychiatric:	**Memory Loss** **Anxiety**	**Insomnia**	**Depression**	**Mood swings**
Endocrine:	**Excessive thirst**	**Excessive urination**	**Heat intolerance**	**Cold intolerance**
Hematological, Lymphatic:	**Phlebitis** **Bruising easy**	**Anemia** **Bleeding problems**	**Past transfusion** **Blood clots**	**Large lymph nodes**
Allergic, Immunology:	**Seasonal allergies** **Hives**	**Frequent colds** **Sneezing**	**Runny nose**	**Itchy eyes**

Breast Questionnaire:_____ **Medical Assistant Initials _____**

SURGICAL HISTORY

List Previous surgery and procedures: (What, When, Where and Type of Anesthesia)

_____
_____
_____
_____
_____
_____
_____
_____
_____

PERSONAL AND FAMILY HISTORY

Check any of the following that apply to you or your family and explain in detail in the remarks section with dates and treatments.

	Me	Fam			Me	Fam	
Atrial Fibrillation				Breast Cancer			
Angina				Lung Cancer			
Heart Attack				Colon Cancer			
Heart Disease				Prostate Cancer			
Mitral valve prolapse				Other Cancer			
High Cholesterol				Radiation Therapy			
High Lipids				Chemotherapy			
High Blood Pressure				Prostate enlargement			
Coumadin therapy				Internal bleeding			
Pacemaker Implant				Seizure Disorder			
Stroke				Major Trauma			
Emphysema				Bleeding Problems			
Pneumonia				Orthopaedic Problem			
Asthma				Arthritis			
Colitis				Joint Disease			
Difficulty Eating				Mental Illness			
Gerd				Unexplained Weight Loss			
Diabetes				AIDS/HIV			
Kidney Disease				Anesthesia Problems			
Hepatitis				Alcoholism			
Thyroid Disease							

Remarks: (Please explain any boxes you checked)

_____
_____
_____
_____

TOBACCO USE

	YES	NO	AMOUNT/NUMBER OF YEARS	WHEN DID YOU QUIT?
Alcohol Use:				
Tobacco Use:				
Cigarette:				
Cigar:				
Pipe:				
Oral/Snuff:				
Drug Use:				

ALCOHOL and DRUG USE

Alcohol	YES	NO	AMT per DAY/# OF YEARS	WHEN DID YOU QUIT?
Current				
Previous				
Never				
Drugs			**TYPE**	**WHEN DID YOU QUIT?**
Current				
Previous				
Never				

Patient Signature _____Date _____

Physician Signature _____Date _____