Gerig Surgical Associates, P.C.
Medical Health History Form

Name: _____ **Sex:** □ Male □ Female **Date:** _____

Date of Birth: _____ **Age:** _____ **Referring Doctor:** _____ **Family Doctor:**_____

The reason for my visit today is: _____

Height:_____ **Weight:** _____

List Allergies or Reactions to Medication(s): □ None, □ Latex, □ Contrast Dye, □ Iodine, □ Shellfish, □ Penicillin, □ Sulfa, □ Other_____
_____

List all Prescribed and Non-Prescribed Medications, Aspirin, Vitamins, and Supplements: □ None
□ Attached List - **If you have brought a medication list you do NOT need to write them below**
□ **Aspirin** dose_____ frequency_____

Medication	Dose	Frequency	Medication	Dose	Frequency

Personal Medical History: Mark all that apply to you.

□ Anemia	□ Convulsions/Seizures	□ High Blood Pressure	□ Gastrointestinal Disease
□ Arthritis	□ Heart Disease	□ High Cholesterol	□ Colon Polyps
□ Asthma	□ Congestive Heart Failure	□ Kidney Disease	□ Reflux (GERD)
□ Blood Disorder	□ Pacemaker	□ Cirrhosis	□ Ulcers, Stomach
□ Blood Transfusion	□ Diabetes	□ Prostate Problem	□ Stroke
□ Emphysema/COPD	□ Hepatitis A B C	□ Pancreatitis	□ Psychiatric Care
□ Peripheral Vascular Disease	□ HIV	□ Thyroid Problems	□ Ulcers/Wounds Skin
□ Obesity	□ Sleep Apnea	□ Covid19 Date:_____	□ Covid Vaccine Date:_____

□ Cancer – Type(s): _____
Other/Additional Information: _____
Have you had any Previous Surgeries? □ Yes □ No

	Back		Lung Right or Left		Cesarean
	Hip Right or Left		Tonsillectomy		D & C
	Knee Right or Left		Sinus		Kidney
	Rotator Cuff Right or Left		Heart Valve		Bladder
	Amputation		Heart By-Pass		Vasectomy
	Carpal Tunnel Right or Left		Pacemaker		Prostate
	Appendectomy		Heart Catheterization		Thyroid Right or Left
	Gallbladder Surgery		Stents in Heart		Craniotomy
	Hernia		Carotid Artery Right or Left		Ears
	Upper Scope (EGD)		Abdominal Aneurysm		Eye
	Colonoscopy		Varicose Vein Right or Left		Wisdom Teeth
	Sigmoidoscopy		Arterial By-pass Right or Left		Pilonidal cyst
	Nissen		Breast Right or Left		
	Colectomy or colostomy		Hysterectomy		
	Hemorrhoid		Oophorectomy(Ovary)Right or Left		
	Bariatric		Tubal ligation		

Have you had any problems with anesthesia? _____ Yes _____ No

Recent Hospitalizations/Tests? _____
(Related to this Visit)

(Please, turn over and complete back of form.)

Family History: First Degree Relatives - Parents, Siblings, Grandparents, Children □ **Adopted**

□ Colon Cancer _____ □ Other Cancer _____ □ Heart Disease _____
□ Thyroid Problems _____ □ Blood Disorder _____ □ Diabetes _____
□ Crohn's/UC_____ □ Stroke_____ □ Other Medical Conditions_____

Social History:

Caffeine Use: □ No □ Yes ___ Coffee/Cups/Day; ___Soda/Cans/Day; ___ Tea/Cans/Day
Alcohol Use: □ Never □ Social/Rare □ Moderate (2 drinks/day or fewer) □ More than 2 drinks/day
Illegal Drug Use: □ Never □ Yes Type/Frequency _____
Tobacco Use: □ Never □ Yes Smoking ___ Packs/Day, □ Quit – How long ago? _____, □ Chewing Tobacco □ Vaping
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Occupation: _____

System Review: Mark the ones you currently are having.

Constitutional (General)
- □ Loss of Weight
- □ Fatigue
- □ Fever
- □ Night Sweats

Eyes
- □ Change in Vision – Rt or Lt

Ears, Nose, Mouth & Throat
- □ Difficulty Swallowing
- □ Hard of Hearing
- □ Broken or Infected Teeth

Cardiovascular
- □ Chest Pain
- □ Irregular Heart Beat
- □ Heart Palpitations
- □ Swelling in Legs

Genitourinary
- □ Pregnant/_____Weeks
- □ Abnormal Menses
- □ Incontinence/Dribbling
- □ Erectile Dysfunction
- □ Painful Urination
- □ Blood in Urine
- □ Testicular Lump – Rt or Lt

Gastrointestinal
- □ Abdominal Pain
- □ Loss of Appetite
- □ Bloating
- □ Indigestion/Heartburn
- □ Nausea
- □ Vomiting
- □ Vomiting Blood
- □ Excessive burping
- □ Constipation
- □ Diarrhea
- □ Rectal Bleeding
- □ Change in Bowel Habits
- □ Black Stools/Melena
- □ Hemorrhoids

Neurological
- □ Fainting
- □ Confusion/Disorientation
- □ Tremors
- □ Dementia

Musculoskeletal
- □ Back Pain
- □ Difficulty Walking
- □ Joint Pain/Stiffness

Integumentary (Skin/Breast)
- □ Jaundice
- □ Change in Moles
- □ Sores/Ulcers Skin
- □ Breast Discharge – Rt or Lt
- □ Breast Lump – Rt or Lt

Respiratory
- □ Coughing Up Blood
- □ Shortness of Breath
- □ Wheezing

Endocrine
- □ Hormone Problems
- □ Hot Intolerance
- □ Cold Intolerance
- □ Obesity
- □ Uncontrolled Diabetes

Psychiatric
- □ Anxiety
- □ Psychological symptoms
- □ Depression
- □ Excessive Stress

Hematological/Lymphatic
- □ Enlarged Glands

My signature below certifies the above to be correct to the best of my knowledge and that any errors will be my responsibility alone:

Patient Signature: _____ **Date:** _____