

# Gerig Surgical Associates, P.C.

## Medical Health History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Sex:  Male  Female

The reason for my visit today is: \_\_\_\_\_

**Personal Medical History:** (Mark all that apply to you.)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Convulsions/Seizures     | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease     |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Coronary Heart Disease   | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Reflux (GERD)    |
| <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Blood Transfusion    | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Problem  |
| <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Heart Defect             | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Ulcers, Stomach  |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hepatitis A B C          | <input type="checkbox"/> Prostate Problem    | <input type="checkbox"/> Ulcers, Skin     |

Cancer – Type(s): \_\_\_\_\_

Other/Additional Information: \_\_\_\_\_

**List Allergies or Reactions to Medication(s):**  None

\_\_\_\_\_

**Have you had any Previous Surgeries/Hospitalizations/Tests?**  Yes  No

Please, list any surgeries and the date of occurrence:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Social History:**

Caffeine Use:  No  Yes \_\_\_\_\_ Cups/Day; \_\_\_\_\_ Cans/Day

Tobacco Use:  Never  Yes \_\_\_\_\_ Packs/Day  Quit - How long ago? \_\_\_\_\_

Alcohol Use:  Never  Rarely  Moderate  Daily

Drug Use:  Never Type/Frequency \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Excessive Exposure at Work/Home to:  Fumes  Dust  Solvent  Noise  Airborne Particles

Occupation/Location: \_\_\_\_\_

**Family History:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Depression       | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Breast Cancer     | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Colon Cancer      | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Other: _____     |

**List all Medications & Vitamins:** (Name, Dose & Frequency)  None  Attached List

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**System Review:** (Mark the ones you currently are having or had in last three months.)

Constitutional (General)

- Weight Gain
- Loss of Weight
- Weakness/Fatigue
- Severe Headaches
- Fever/Night Sweats

Eyes

- Change in Vision

Ears, Nose, Mouth & Throat

- Bleeding Gums
- Hoarseness
- Ringing in Ears

Cardiovascular

- Chest Pain
- Irregular Heart Beat
- Poor Circulation
- Swelling in Legs
- Palpitations

Genitourinary

- Pregnant/\_\_\_\_\_Weeks
- Incontinence/Dribbling
- Abnormal Menses
- Painful/Frequent Urination
- Blood in Urine
- Erectile Dysfunction
- Testicular Lump – Rt or Lt

Gastrointestinal

- Abdominal Pain
- Loss of Appetite
- Change in Bowel Habits
- Bloating
- Indigestion/Heartburn
- Difficulty Swallowing
- Constipation
- Diarrhea
- Excessive Gas
- Rectal Bleeding
- Nausea
- Vomiting
- Vomiting Blood
- Black Stools/Melena

Neurological

- Fainting
- Dizzy/Lightheaded
- Numbness/Tingling
- Seizures/Tremors

Musculoskeletal

- Back Pain
- Difficulty Walking
- Muscle Pain
- Joint Pain/Stiffness

Integumentary (Skin/Breast)

- Jaundice
- Bruise Easily
- Change in Moles
- Sores/Ulcers
- Breast Discharge – Rt or Lt
- Breast Lump – Rt or Lt

Respiratory

- Chronic Cough
- Coughing Up Blood
- Shortness of Breath
- Asthma/Wheezing
- Emphysema

Endocrine

- Hormone Problems
- Hot Intolerance
- Cold Intolerance

Psychiatric

- Anxiety
- Excessive Stress
- Depression

Hematological/Lymphatic

- Bleeding Disorder
- Enlarged Glands
- Hepatitis A B C/HIV
- Anemia

***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:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Physician Use Only:**

**Anesthesia History:** \_\_\_\_\_

**Previous Problems:**  Yes  No

If yes, list: \_\_\_\_\_

**Difficult Airway:**  Yes  No **ASA:** 1 2 3 4 5