St. Francis Surgical Associates

Health History

Name_____Today's Date_____ Date of Birth _____

Primary Care Physician_____Date of Last Physical Exam _____

What is the reason for your visit? _____

General
- Loss of Weight
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headaches
- Loss of sleep
- Sweats

Skin
- Bruise easily
- Changes in moles
- Hives/itching
- Rash

Gastrointestinal
- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain

Cardiovascular
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swollen ankles
- Varicose veins
- Shortness of breath

Genito-Urinary
- Blood in urine
- Frequent urination
- Lack of bladder control

Musculoskeletal
- Joint pains
- Paralysis/weakness
- Muscular pain
- Fractures
- Herniated discs

Eye, Ear, Nose, Throat
- Persistent cough
- Ringing in the ears
- Sinus problems

Screenings

Date of last Pap smear _____

Have you had a mammogram? ☐ Yes ☐ No

If yes, date of last mammogram _____

Have you had a colonoscopy? ☐ Yes ☐ No

If yes, date of last colonoscopy _____

Have you had an upper endoscopy? ☐ Yes ☐ No

If yes, date of last upper endoscopy _____

Conditions: Check conditions you have now or had in the past

- Alcoholism
- Anemia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Cataracts
- Cancer
- Drug Dependency
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- Kidney Disease
- Liver Disease
- Migraine Headaches
- Infectious Disease
- Mononucleosis
- Multiple Sclerosis
- Osteoporosis
- Pacemaker
- Pneumonia
- Prostate Disease
- Psychiatric Care
- Rheumatoid Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Others_____

If you checked any of these conditions, please describe and give approximate date when the condition was acquired.

_____

_____

_____

Did you ever have a blood transfusion? ☐ Yes ☐ No If yes, please give approximate date(s)_____

(Please turn over)

Name_____ Date of Birth_____

Medications: List medications dose and frequency (include Vitamins and herbal medications)

Allergies: List allergies to medication(s) or substance(s). Describe your allergic reaction.

Allergy	Reaction

Hospitalizations/Surgeries:

Year	Reason for hospitalization/surgery	Hospital

Health Habits: Fill out all that apply

Substance	How much/how often you use	Date of last use
Caffeine		
Tobacco (past 12 months)		
Recreation Drugs		
Alcohol		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of these forms.

Patient Signature Date