Please Fill out Health History as completely as possible. Front and Back ……please

Patient Name: _____ **DOB**: _____

Health History

Today's Problem _____

How Often____ daily ____ weekly ____ occasionally

When did the problem begin_____

What makes the problem better _____

This problem is located _____

What makes the problem worse _____

Do you smoke? _____If yes, how much _____

Do you drink alcohol? If yes, how much _____

Weight_____ Height _____

Workers Comp _____ Date of Injury_____

Have you had a flu vaccination this year ? _____

Have you had a pneumonia vaccination this year? _____

Please (x) conditions you have today or have had in the past:

___ Asthma
___ Breast Cancer
___ Cancer
___ Chronic Renal Failure
___ Cirrhosis
___ Colon Polyps
___ Colorectal Malignancy
___ Congestive Heart Failure
___ Crohn's Disease/Colitis
___ Diabetes
___ Diverticular Disease
___ Emphysema/COPD
___ Gastro Esophageal Refux Disease
___ Heart Disease/CAD
___ HIV Infection
___ Hypertension/High Blood Pressure
___ Melanoma
___ Pancreatitis
___ Seizures
___ Stroke
___ Thyroid

Other: _____

Please (X) any blood relative illnesses that have occurred:

___ Diabetes ___ Cancer
___ Kidney Disease ___ Heart Disease
___ Stroke ___ Colon Cancer
___ Anesthesia Complications

Please (x) if allergic to the following:

___ Penicillin ___ Latex
___ Sulfa

Other: _____

Please (x) the surgeries that you have had in the past:

___ **A**bdominal Surgery
___ Biopsy _____
___ Colon Surgery
___ Egd
___ Hiatal/Paraesophageal hernia
___ Kidney Surgery
___ Mastectomy
___ Umbilical Hernia Surgery
____ Appendectomy
____ Cardiac Cath
____ Colonoscopy
____ Exploratory Laparotomy
____ Hip Surgery
____ Lung Surgery
____ Pacemaker/Defibrillator
____Vascular Surgery
____ Aortic Aneurysm Repair
____ Cholecystectomy (gallbladder)
____ C-Section
____ Groin/Hernia surgery
____ Hysterectomy
____ Knee Surgery
____ Tubal
____ Ventral/Incisional Hernia

Other: _____

Please circle if you are on **blood thinners, heart medications, aspirin or phentermine**

List name(s) of medication(s):

Review of Symptoms - Check (x) symptoms you currently have or have had in the past year

Constitutional
___ chills
___ dizziness
___ fever
___ night sweats

Eyes
___ blurred vision
___ glasses/contacts
___ visual disturbance

Ears/Nose/Throat/Neck
___ trouble swallowing
___ neck mass
___ sore throat

Cardiovascular
___ chest pain/pressure
___ black outs (fainting)
___ cold extremities
___ leg pain at rest
___ leg pain walking
___ swelling

Respiratory
___ asthma
___ copd
___ cough
___ sleep apnea-obstruction
___ snoring

Gastrointestinal
___ abdominal pain
___ bulge
___ constipation
___ heartburn
___ bloating
___ bowel habit change
___ indigestion
___ appetite change
___ poor appetite
___ black bowel movement
___ blood in stool
___ rectal bleeding
___ hemorrhoids
___ diarrhea
___ hernia
___ vomiting

Genitourinary/Nephrology
___ burning
___ inability to urinate
___ blood in urine

Musculoskeletal
___ joint pain
___ muscle pain
___ back pain

Dermatologic
___ changing moles
___ growths
___ new lesions
___ skin cancer
___ sores

Neurological
___ memory loss
___ seizures
___ stroke

Psychiatric
___ depression
___ alcohol abuse
___ drug abuse

Endocrine
___ weight gain
___ weight loss
___ diabetes
___ thyroid problems

Hematologic/Lymphatic
___ bleeding tendencies
___ bruising
___ anemia

Women Only
Pregnant ___ yes ___ no Due Date_____

Mammogram ___ yes ___ no Date_____

Reviewed by_____ Date _____

Signatures
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. As a patient of the Ozark Surgical Associates, I do hereby voluntarily consent to such medical care and treatment encompassing standard diagnostic procedures, and the performance of any other procedures by the Ozark Surgical Associates as their judgment deems medically advisable.

I understand that if I have any questions regarding my examination, I may request an explanation at any time. (Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.)

_____ _____
Signature of Patient, Guardian, or Personal Representative Date

_____ _____
Please Print Name of the Above Signature Relationship to Patient