GREAT SOUTH BAY SURGICAL ASSOCIATES
MEDICAL HISTORY FORM

PATIENT: ____ DATE: ___________________________

CHIEF COMPLAINT: ____
Have you had any recent x-rays or lab work relating to this complaint? ___________________________
If yes, when and where? ____

HEIGHT: __________________________________ WEIGHT: ___________________________

HISTORY OF PRESENT COMPLAINT:
Location of pain/problem: ____
How severe is the pain or problem? : ____
Does this pain/problem occur at a specific time? If yes, when? _________________________________
What other signs/symptoms are you having? ____
How long have you had this pain/problem? ____
What makes the pain/problem worse or better? ____
Have you had any previous episodes? If yes, when? ____
Are you **ALLERGIC** to any medicine? If yes, please list and give reactions _______________________
____
Are you taking any Herbal supplements/Vitamins, if yes please list______________________________

PATIENT MEDICAL HISTORY: (CIRCLE ONE)

Diabetes	No	Yes	Hypertension	No	Yes
Cancer	No	Yes	Stroke	No	Yes
Heart Disease	No	Yes	Arthritis/Gout	No	Yes
Convulsions	No	Yes	Bleeding Tendency	No	Yes
Thyroid Disease	No	Yes	Vascular Disease	No	Yes
Heredity Defects	No	Yes	Asthma	No	Yes

MEDICATIONS & DOSAGES: ____
____
____
____
PERFERRED PHARMACY___________________ PHARMACY ADDRESS & PHONE # ______________
____
PAST SURIGICAL HISTORY: ____
____
____

PATIENT SOCIAL HISTORY:
Martial Status: Single: ____ Married: ___ Separated: ____ Divorced: ____ Widowed: ____
Use of Alcohol: Never: _____ Rarely: ____ Moderate: ____ Daily: _____
Use of Tobacco: Never: _____ Previously, but quit: _____ Current: _____ # of packs per day ____
Use of Drugs: Never: _____ Type/Frequency: ____

FAMILY MEDICAL HISTORY:

	Age	Diseases	If Deceased, Cause of Death
Mother:	_____	___________________________	___________________________
Father:	_____	___________________________	___________________________
Siblings:	_____	___________________________	___________________________
	_____	___________________________	___________________________
Children	_____	___________________________	___________________________
	_____	___________________________	___________________________

PLEASE CONTINUE ON BACK PAGE

PATIENT NAME: ____

CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

CADIOVASCULAR

Heart Disease	No	Yes
Chest Pain or Angina	No	Yes
Palpitations	No	Yes
Shortness of breath with walking	No	Yes
Swelling of Feet	No	Yes

RESPIRATORY

Chronic frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change of bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent Diarrhea	No	Yes
Painful bowel movements	No	Yes
Peptic ulcers	No	Yes
Rectal bleeding/blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Constipation	No	Yes

GENITOURINARY

Frequent Urination	No	Yes
Burning or Painful Urination	No	Yes
Blood in Urine	No	Yes
Change in urine flow	No	Yes
Incontinence/dribbling	No	Yes
Kidney Stones	No	Yes
Pain during intercourse	No	Yes
Male: Testicle pain	No	Yes
Female: Breast pain	No	Yes
Nipple discharge	No	Yes
Change in breast appearance	No	Yes

Of pregnancies ___________

Of miscarriages ___________

Date of last pap smear: _________________

Date of last menstrual period: _______________

MUSCULOSKELETAL

Joint Pain	No	Yes
Joint stiffness/swelling	No	Yes
Weakness of muscle/joint	No	Yes
Muscle pain or cramps	No	Yes
Back Pain	No	Yes
Cold Extremities	No	Yes
Difficulty in walking	No	Yes

INTGUMENTARY SYSTEM

Rash or Itching	No	Yes
Change in skin color	No	Yes
Varicose Veins	No	Yes
Breast Pain	No	Yes
Breast Lump	No	Yes
Breast Discharge	No	Yes
Bloody discharge nipple	No	Yes

NEUROLOGICAL

Freq. Or recurring headache	No	Yes
Head Injury	No	Yes
Lightheaded or dizzy	No	Yes
Numbness or tingling	No	Yes
Convulsions or seizures	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding/Bruising	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past Transfusion	No	Yes
Enlarged glands	No	Yes

ALLERGIC/IMMUNOLOGIC			**REACTION**
Penicillin	No	Yes	__________
Other antibiotics	No	Yes	__________
Morphine/Demerol	No	Yes	__________
Novocain or anesthetics	No	Yes	__________
Aspirin or pain remedies	No	Yes	__________
Tetanus antitoxin/serums	No	Yes	__________
Iodine or antiseptics	No	Yes	__________
Latex	No	Yes	__________

other drug medications: ________________

____

Food Allergies: __________________________

Date of most recent colonoscopy: ____

Date of most recent mammogram: (if applicable) ____

Date of most recent influenza vaccine: ____

Date of most recent pneumococcal immunization: ____

____

PHYSICIAN SIGNATURE

____

DATE

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