Surgical Associates of Marshall County
Health History Form

Date: _____ Name: _____

Date of Birth: _____ Height: _____ Weight:_____ BMI: _____

Medications you are currently taking: (Please include dosage and frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently taking any of the following blood thinners?

☐ Aspirin ☐ Plavix ☐ Coumadin

Allergies to Medications: ☐ No known drug allergies ☐ Latex Allergy

_____ _____

_____ _____

_____ _____

Past Hospitalizations and Surgeries: (Please list date, hospital, and procedure)

_____ _____

_____ _____

_____ _____

Do you have any of the following?

☐ High blood pressure ☐ Diabetes ☐ Heart Disease

☐ Reflux (heartburn) ☐ Sleep Apnea ☐ with C-PAP

Medical History and Review of Systems

Do you have, or have you ever had: (Please check all that apply)

Cardiac: ☐ Shortness of Breath ☐ Heart cath/stents ☐ Abnormal Stress Test/EKG
☐ Atrial fibrillation

General: ☐ Cancer ☐ HIV ☐ Headaches ☐ Weight loss
☐ Weight gain ☐ Snoring

GI: ☐ Nausea/vomiting ☐ Throwing up blood ☐ Difficulty swallowing ☐ Constipation
☐ Diarrhea ☐ Abnormal bowel movements ☐ Blood in bowel movements
☐ Colored bowel movements

Pulmonary: ☐ Coughing up blood ☐ Wheezing ☐ Cough

Skin: ☐ Black spot ☐ Skin lesion that has changed shape/size/color
☐ Skin lesion that bleeds

Vascular: ☐ Ulcer on legs ☐ Varicose veins ☐ Spider veins

Social History: ☐ Alcohol ☐ Illicit Drugs ☐ Tobacco

Immediate Family's Health History: (State of health/medical conditions or cause of death)

Father: _____

Mother: _____

Siblings: _____

Children: _____

WOMEN ONLY:
Approximate date of last menstrual period: _____ Last mammogram: _____

Additional patient comments: _____

_____

_____

By signing below, I am stating that I have filled out the above health and medical history to the best of my knowledge. Any item left blank is to be considered answered in the negative (no or none).

X _____
Signature