METHODIST PHYSICIANS CLINIC

SURGICAL ASSOCIATES HEALTH HISTORY

Patient Name:_____ Date: _____

Age:_____ Date of Birth:_____ Sex: M F Date of last physical exam:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

What is reason for your visit? _____

Primary Physician:_____ Referring Physician: _____

REVIEW SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Shortness of breath
- ☐ Sweats
- ☐ Weight gain
- ☐ None

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ None

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ None

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Food Intolerances (greasy/fried)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Swallowing problems
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ None

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ None

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Sores in mouth or throat
- ☐ Vision-Flashes
- ☐ Vision-Halos
- ☐ None

SKIN
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal
- ☐ None

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other
- ☐ None

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Menopause
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other
- ☐ None

Date of last:

Menstrual period:_____

Pap smear:_____

Mammogram:_____

Do you use birth control? ☐Yes ☐No

Have you been hit, slapped, kicked or otherwise physically injured by someone? ☐Yes ☐No

If Yes, explain: _____

Any other symptoms not listed: _____

_____

_____

_____

< over >

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

METHODIST PHYSICIANS CLINIC

CONDITIONS: Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ DVT
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ PE
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Transfusions
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Any other symptoms not listed: _____

CURRENT MEDICATIONS Include prescription, over-the-counter and herbals:

NAME OF MEDICINE	DOSE	HOW OFTEN TAKEN	REASON FOR TAKING	LENGTH OF TIME TAKEN

ALLERGIES: List any allergies you have to Medications, food or environment:_____

_____

_____

Do you have a **LATEX** sensitivity or allergy?..... ☐ Yes ☐ No

Following a medical, surgical or dental procedure, have you ever had any unexplained itching, hives, swelling or anaphylactic reaction? ..... ☐ Yes ☐ No

Have you had symptoms such as sneezing, coughing, rash or hives when handling rubber products, balloons, latex gloves or Band-Aid's?.. ..... ☐ Yes ☐ No

Please complete the TABLE below for any PRIOR cancer, radiation, treatment, or chemotherapy that you may have had:

	Don't know	No	Yes	Year	Kind of cancer or Type of disease / condition
Prior Cancers:					
Prior Radiation Treatment (not dental x-rays or broken bones):					
Prior Chemotherapy:					

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

METHODIST PHYSICIANS CLINIC

FAMILY HISTORY: Are you Adopted? ☐ Yes ☐ No
Are you a Twin? ☐ Yes ☐ No If yes, what type of twin? ☐ Identical ☐ Fraternal ☐ Don't know
Excluding yourself, how many of each of the following blood-related family members do you have? Remember to include those who are no longer living. Include only **full** brothers or sisters. Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

FAMILY HISTORY – Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Grandparents				

Check (✓) if your blood relatives had any of the following:

Disease	Relationship to you
☐ Allergies	
☐ Anemia	
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Malignant Hyperthermia	
☐ Tuberculosis	

HOSPITALIZATIONS/SURGERIES

Year	Hospital	Reason for Hospitalization and Outcome

Have you had any reaction to anesthesia? ☐ Yes ☐ No
Do you take any anticoagulants (i.e. Aspirin, Coumadin, Plavix)? ☐ Yes ☐ No
If so, please list:_____
Do you have a pacemaker, defibrillator or stent of any kind? ☐ Yes ☐ No
If so, please list:_____

Have you ever had a chest x-ray? ☐ Yes ☐ No Date: _____
Flu Vaccine? ☐ Yes ☐ No Date: _____
Pneumovax? ☐ Yes ☐ No Date: _____
Tetanus? ☐ Yes ☐ No Date: _____
Do you use seat belts? ☐ Yes ☐ No
If you have children do you use a car safety seat? ☐ Yes ☐ No

SERIOUS ILLNESS/ INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Complications (if any)

Are you pregnant? ☐ Yes ☐ No

HEALTH HABITS: Check (✓) which substances you use and describe how much you use.

☐ Caffeine	
☐ Tobacco	
☐ Vaping	
☐ Street Drugs	
☐ Alcohol	
☐ Other	

OCCUPATIONAL CONCERNS: Check (✓) if your work exposes you to the following:

☐ Stress
☐ Hazardous Substances
☐ Heavy Lifting
☐ Other
Your occupation:

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, have a change in health. **Please use reverse side for additional information.**

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

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Label
NAME:_____DOB:_____
FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD