

THE SURGICAL CARE GROUP HEALTH QUESTIONNAIRE

Today's date: _____

Patient Name: _____ SS# _____ - _____ - _____ M F Age: _____

Birthdate: _____ Height: _____ Weight: _____ Marital Status: M S D W Sep

Primary Care Physician: _____ Referring MD: _____

Occupation: _____

Reason for your visit today (please describe your injury or problem, in detail) _____

PERSONAL MEDICAL HISTORY: Have you ever had any of the following conditions? Leave blank if uncertain.

Arthritis (other than back)	NO	YES	Anemia	NO	YES
Diabetes	NO	YES	Bleeding tendencies	NO	YES
Kidney failure	NO	YES	Kidney stones	NO	YES
High Cholesterol	NO	YES	Psoriasis	NO	YES
Thyroid disorder	NO	YES	Stroke	NO	YES
Liver disease	NO	YES	Migraine headaches	NO	YES
Hepatitis	NO	YES	Depression	NO	YES
Gall Bladder disease	NO	YES	Epilepsy	NO	YES
Stomach ulcers	NO	YES	HIV/AIDS	NO	YES
Colitis	NO	YES	Glaucoma	NO	YES
Hemorrhoids	NO	YES	Gout	NO	YES
High blood pressure/hypertension	NO	YES	Shingles	NO	YES
Heart disease	NO	YES	Tuberculosis	NO	YES
Asthma/lung disease	NO	YES	Venereal disease	NO	YES
Blood/plasma transfusions	NO	YES	Cancer _____	NO	YES
Blood clots	NO	YES	Other _____		

OPERATIONS/ HOSPITALIZATIONS:

Reason:

Date:

<u>ALLERGIES:</u>	Shellfish	NO	YES	X-ray Contrast/dye	NO	YES
	Latex	NO	YES	Local Anesthetic	NO	YES

MEDICATION ALLERGIES: (if none please state so) _____

CURRENT MEDICATIONS:

<u>Name:</u>	<u>Dose:</u>	<u>Frequency:</u>	<u>Reason:</u>

FAMILY HISTORY: List immediate family members with the following:

Diabetes	NO	YES	
Cancer	NO	YES	
Gout	NO	YES	
Heart disease	NO	YES	
Hypertension	NO	YES	
Other (Specify)	NO	YES	

HEALTH HABITS/DIETARY SUPPLEMENTS:

Explain:

Vitamins	NO	YES	_____
Calcium	NO	YES	_____
Estrogen	NO	YES	_____
Tobacco	NO	YES (Type/Amount per day)	_____
Have you ever smoked	NO	YES (if you quit, date you quit)	_____
Alcohol	NO	YES	_____
Drug Use	NO	YES (Type/Frequency)	_____
History of drug or alcohol abuse	NO	YES (describe)	_____
Caffeine	NO	YES (Type/Frequency)	_____
Exercise	NO	YES (Type/Frequency)	_____

REVIEW OF HEALTH SYSTEMS: Please **circle** any problems you have had in the past six months.

Weight gain/loss-more than 10 lbs.
 Chills
 Unexplained night fever
 Night Sweats
 Marked Fatigue

HEAD:

Headache
 Facial Pain
 Sinus Pain

EYES:

Blurred/Double Vision
 Light Sensitivity (Photophobia)
 Eye Pain
 Eye Itching

OTOLARYNGEAL (EARS/NOSE):

Earache
 Hearing Loss
 Nose Bleeds
 Nasal Discharge
 Mouth Sores
 Bleeding Gums
 Hoarseness
 Throat Pain
 Chronic Sinus Problems

NECK:

Neck Pain
 Neck Stiffness
 Lump/Swelling Neck

BREAST:

Pain
 Discharge
 Lump

CARDIOVASCULAR:

Chest Pain/tightness/pressure

Fast Heart Rate
 Palpitations

PULMONARY (LUNGS):

Shortness of breath
 Recurrent Cough
 Coughing up blood (hemoptysis)
 Wheezing
 Other _____

GASTROINTESTINAL:

Appetite Change
 Difficulty Swallowing
 Heartburn/indigestion
 Nausea
 Vomiting
 Persistent recurring belly pain

Diarrhea

Blood in stool
 Uncontrolled loss of stool
 Pain with bowel movement
 Constipation

UROLOGICAL:

Difficulty with urination
 Increased urinary frequency
 Blood in urine (hematuria)
 Pain/burning on urination
 Uncontrolled loss of urine
 Urinary tract infection

SKIN:

Itching
 Skin lesions
 Rashes
 Skin change

ENDOCRINE:

Excessive sweating

Night sweats
 Excessive thirst (polydypsia)
 Sex drive (libido) has changed
 Liver disease
 Jaundice

High cholesterol
 Hepatitis
 Diabetes
 Thyroid Problem

SKELETAL:

Joint Pain
 Joint Stiffness
 Muscle Aches
 Joint redness
 Joint swelling

NEUROLOGICAL:

Dizziness/vertigo
 Fainting
 Motor disturbances (tremors, numbness)
 Sensory disturbances
 Seizures

PSYCHOLOGICAL:

Difficulty Sleeping
 Anxiety
 Depression

HEMATOLOGIC/LYMPHATIC:

Enlarged glands
 Other _____

REPRODUCTIVE SYSTEM:

Date of last menstrual cycle _____

Any other information of which the doctor should be aware? _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status.

Signature: _____

Date: _____