HEALTH HISTORY – SURGICAL ASSOCIATES, PC
1001 S 70th Street Suite 100
Lincoln, NE 68510

Date:_____

Name _____ Age _____ Gender: M / F
Family Doctor:_____ Sent to our office by:_____

PLEASE FILL OUT IN ITS ENTIRETY.

Reason for seeing doctor: Problem/Symptoms: _____
Currently Treated/Chronic Medical Problems:

- ❑ Acid Reflux
- ❑ Afib
- ❑ Cancer (type_____)
- ❑ COPD
- ❑ Depression
- ❑ Factor 5 Leiden Mutation
- ❑ Hypertension/High Blood Pressure
- ❑ HIV
- ❑ Joint Pain (joint_____)
- ❑ Malignant Hyperthermia
- ❑ PCOS
- ❑ Renal Disease
- ❑ Type II diabetes
- ❑ Weight related injury (specify _____)
- ❑ Anxiety
- ❑ BPH (Benign Prostatic Hyperplasia)
- ❑ CHF (Congestive Heart Failure)
- ❑ Crohn's
- ❑ Diverticulitis
- ❑ GERD
- ❑ Hypothyroid
- ❑ Back Pain
- ❑ Morbid Obesity
- ❑ Pneumonia
- ❑ Sleep Apnea
- ❑ Ulcerative Colitis
- ❑ Asthma (type_____)
- ❑ Coronary Artery Disease
- ❑ Chronic Migraines
- ❑ CVA (Cerebral Infarction)
- ❑ Emphysema
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ IBS (Irritable Bowel Syndrome)
- ❑ Obstructive Sleep Apnea
- ❑ Psychological Illness
- ❑ Type I diabetes
- ❑ Urinary Incontinence
- ❑ Pregnant (week gestation _____)
- ❑ Other: _____

Prior Surgeries & Approximate Date: (please circle or fill in blanks, **dates can be written in below the procedure)**

- ❑ Adenoidectomy
- ❑ Appendectomy
- ❑ Bone Surgery (location _____)
- ❑ Back Surgery
- ❑ Carpal Tunnel Surgery
- ❑ Cholecystectomy (gallbladder)
- ❑ Colon Resection (site _____)
- ❑ Coronary Artery Bypass (# ___)
- ❑ Gastric Bypass
- ❑ Gastric Sleeve
- ❑ Heart Cath
- ❑ Heart Stent
- ❑ Hernia Repair (location_____)
- ❑ Hip Replacement (total/partial)
- ❑ Hip Scope
- ❑ Hysterectomy (vaginal/abdominal)
- ❑ Excisional Breast Biopsy
- ❑ Knee Replacement (side_____)
- ❑ Knee Scope (side_____)
- ❑ Lap Band
- ❑ Lithotripsy
- ❑ Mastectomy (total/partial)
- ❑ Sinus Surgery
- ❑ Tonsillectomy
- ❑ Tubal Ligation
- ❑ Vasectomy
- ❑ Wisdom Teeth Extraction
- ❑ Cesarean Delivery
- ❑ Other: _____

Date Of Last:
Colonoscopy: _____
Mammogram: _____
PAP Smear: _____
Influenza Vaccine: _____
Pneumonia Vaccine: _____
(if over age 65)

Medications: list dosage & how often (include over-the-counter & herbal): _____
_____
_____

Medication **ALLERGIES** and type of reaction (including Latex): _____
_____

Family history of medical problems: (e.g. cancer, heart disease, etc.) and relationship:
_____
_____
_____

Type of work you do: _____
Do you use tobacco products (including vapor) **or have in past**: Y N If so, how much? _____
How long? _____ Quit? _____
Alcohol consumption: Y N If so, how much? _____
Caffeine: Y N How much? _____
Illegal drug use: Y N If yes, which drug(s)? _____

Do you have any of the following symptoms:

General	*Appetite Loss Fatigue Fever Weight Gain Weight Loss*
Skin	*Non-Healing Wound Open Sore Rash*
HEENT	*Blurred Vision Eye Discharge Eye Pain Hearing Loss Sinus Discharge Sinus Pain Sore Throat Visual Loss*
Neck	*Neck Mass Neck Pain Neck Stiffness Neck Swelling Swollen Glands*
Respiratory	*Bloody Sputum Cough Sputum Production Wheezing*
Cardiovascular	*Chest Pain Shortness of Breath Extremity Swelling*
Gastrointestinal	*Abdominal Pain Bloating Constipation Diarrhea Heartburn Incontinence of Stool Nausea Rectal Bleeding Rectal Pain Vomiting*
Genitourinary	*Blood in Urine Burning Frequency Incontinence Urgency*
Musculoskeletal	*Immobility Joint Stiffness Joint Swelling Muscle Pain*
Neurological	*Blackouts Dizziness Numbness Tingling Weakness*
Psychiatric	*Change in Sleep Pattern Disorientation Hallucinations*
Hematology	*Blood Clots Easy Bleeding Easy Bruising*

1. Do you have any family history of:

	Colon Cancer	Colon Polyps	Colitis	Other Medical Problems
Mother	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	_____
Father	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	_____
Children	❑ yes ❑no	❑ yes ❑ no	❑ yes ❑ no	_____
Brothers/Sisters	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	_____
Grandparents	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	_____
Aunts & Uncles	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no	_____

2. How frequently do your bowels move? ❑ 3+/day ❑ 1-3/day ❑ once every 2-3 days ❑ every 4+days
3. Do you strain to move your bowels? ❑ never ❑ sometimes ❑ frequently ❑ always
4. Typical stool consistency: ❑ watery ❑ loose ❑ soft ❑ firm ❑ hard ❑ lumpy ❑ bloody
5. Do your bowel movements hurt? ❑ yes ❑ no
6. Do you bleed with bowel movements? ❑ yes ❑ no
7. Does tissue ever protrude from the anus after bowel movements? ❑ yes ❑ no ❑ don't know
8. Please list all laxatives, enemas, stool softeners, and fiber supplements you have used to regulate your bowels: _____ _____

For women only:

1. How many children have you had? _____ What are their ages? _____
2. Were any born by Caesarean section? ❑yes ❑ no
3. Were any delivered with forceps? ❑ yes ❑ no
4. Did you have an episiotomy (surgical cut) or tear with any delivery? ❑ yes ❑ no
5. Have you had a hysterectomy? ❑ yes ❑ no If yes, what for? _____
6. If applicable, what was your age at the time of hysterectomy or menopause?_____