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

Name _____ DOB _____ 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- If nothing applies please print N/A _____.

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

Name _____ DOB _____

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)? _____

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:
_____
_____
_____

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?_____