



GENERAL HISTORY FORM

IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____ Age: _____ Date of Birth: _____ Weight: _____ Height: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail address _____ Emergency Contact _____
Emergency Contact Info _____
Emergency Contact relationship to you _____
Social Security#: _____ Occupation: _____
Reason for today's visit: _____

Primary Care Physician: _____ Phone: _____ Fax _____
Address _____ City/State _____ Zip _____

Referring Physician: _____ Phone: _____ Fax _____
Address _____ City/State _____ Zip _____

How Did You Hear About Us? _____

Primary Insurance: _____ Phone #: _____
Address: _____ Policy #: _____ Group #: _____
Policy Holder: _____ Social Security #: _____ DOB: _____

Secondary Insurance: _____ Phone #: _____
Address: _____ Policy #: _____ Group #: _____
Policy Holder: _____ Social Security #: _____ DOB: _____

PAYMENT OPTIONS:

- MasterCard & Visa are accepted
- Personal checks are accepted **at least** 14 days prior to surgery
- Payment financing is available via Care Credit



Do you currently have any of the following conditions?

	YES	NO		YES	NO		YES	NO
EYES			ENDOCRINE			GENITOURINARY		
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain w/ urination	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance(s)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with pills	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with diet	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, THROAT			Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>	CARDIAC			MUSCULOSKELETAL		
Nasal breathing issues	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disk	<input type="checkbox"/>	<input type="checkbox"/>
Use oxygen at home	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Back pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGIC		
GASTROINTESTINAL			Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic nausea	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac bypass	<input type="checkbox"/>	<input type="checkbox"/>	TIA (AKA "minor stroke")	<input type="checkbox"/>	<input type="checkbox"/>
Chronic vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	SKIN		
Black/bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	HEME/LYMPH			Moles	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Recent lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>	Poor scarring	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Hernia(s)	<input type="checkbox"/>	<input type="checkbox"/>						
Spleen problems	<input type="checkbox"/>	<input type="checkbox"/>						

PAST MEDICAL HISTORY:

Have you ever had any of the following?

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer (other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If yes to any of the above, please describe the condition: _____

PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date



FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MIGRAINES	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please describe the condition and identify your relation to the family member: _____

MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

DRUG ALLERGIES: _____

SOCIAL HISTORY:

Marital Status: _____ Spouse's name _____

Are you currently employed? yes ___ no ___ If so, what do you do? _____

Do you smoke? yes ___ no ___ If so, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____