

Social History

Tobacco Use Yes Never Quit Passive

Packs/day 0.25 0.5 1 1.5 2 3

Years 0.5 1 2 3 4 5 10 15

Quit Enter Date

Types Cigarettes Pipe Cigars Snuff Chew

Alcohol Use Yes No

Drinks/Week # Glass(es) of wine

Shot(s) of liquor

Can(s) of beer

Drink(s) with 0.5oz of alcohol

Drug Use Yes No

Types Amphetamines/Meth Anabolic Steroids

Use/Week 1 2 3 4 5 10 15

Benzodiazepines Cocaine Hallucinogens

Marijuana Opioids IV Inhaled Intranasal Oral

Other

Are you currently working? Yes No What is or was your occupation?

Specialty Medical History

1. Have you had any of the following (please check all that apply):

Abnormal ECG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Deep Vein Thrombosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker or Implanted Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Melitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anal Fissure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diverticulitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Arterial Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Embolism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barrets Esophagus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibrocystic Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Mass	<input type="checkbox"/> Yes <input type="checkbox"/> No	GI Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant Trauma or Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burn Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Groin Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemangioma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ventral or Incisional Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cholelithiasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hiatal Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wound Dehiscence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wound Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Mass	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (please specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon Polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiovascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obstructive Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No		

2. If you have or have had any other medical conditions not listed here, please specify.

PT.NO

NAME

DOB

UW Medicine

Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

PATIENT HEALTH HISTORY SURGERY SPECIALTY
PAGE 2 OF 6

U3158

U3158

WHITE - MEDICAL RECORD

UH3158 REV SEP 12

General Medical History

1. Have you had any of the following (please check all that apply):

No Medical Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	CHF	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	PPD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthesia Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Type 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Type 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Substance Abuse	<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	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding/Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	GYN	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lipid/Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please list below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No						

2. If you have or have had any other medical conditions not listed here, please specify.

Past Surgical History

1. Have you had any of the following (please check all that apply):

No Surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cholecystectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia Repair	<input type="checkbox"/> Yes <input type="checkbox"/> No	Splenectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adrenalectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroidectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorectal Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colon Resection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Laparotomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tubal Ligation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anti-Reflux Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cosmetic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Resection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valve Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Esophageal Myotomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreas Resection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vasectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bariatric Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoidectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Please list below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
CABG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Small Bowel Resection	<input type="checkbox"/> Yes <input type="checkbox"/> No		

2. Have you had any previous surgeries for this problem? Yes No

Surgeries for This Problem and if they helped	Surgeon	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. If you have had any other surgeries, please specify.

PT.NO

NAME

DOB

UW Medicine

Harborview Medical Center – UW Medical Center
 Northwest Hospital & Medical Center – University of Washington Physicians
 Seattle, Washington

PATIENT HEALTH HISTORY SURGERY SPECIALTY
PAGE 3 OF 6

U3158

U3158

WHITE - MEDICAL RECORD

REVIEW OF SYSTEMS			Please review and check "no" or "yes" box
Any current problems with your health?		Comments – Additional information	
General	Recent Weight gain / loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current Height: _____ Weight: _____ lbs
	Fatigue / Trouble sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Fever / Chills / Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Anesthesia Problems (self)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Anesthesia Problems (family member)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ear / Nose / Mouth / Throat	Hearing Loss / Hearing Aid	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nose Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Mouth or Throat Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nose bleeds / Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Dental Problems / Dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Loose or Missing Tooth / Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye	Wear glasses / contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Eye problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Yellowing of white part of the eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurology	Problems with vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Headaches / Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Fainting / Unconsciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Numbness / Tingling / Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Recent Heart Attack / MI	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Artificial Heart Valve(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Able to walk two flights of stairs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lung	Shortness of breath (day or night)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Sleep Apnea / Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Difficulty sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Recent cold or cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin	Masses / Bumps / Lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Lesions/ Cuts /Scrapes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Wounds / Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PT.NO

NAME

DOB

UW Medicine

Harborview Medical Center – UW Medical Center
 Northwest Hospital & Medical Center – University of Washington Physicians
 Seattle, Washington

PATIENT HEALTH HISTORY SURGERY SPECIALTY**PAGE 5 OF 6*****U3158***

U3158

WHITE - MEDICAL RECORD

UH3158 REV SEP 12

REVIEW OF SYSTEMS Continued

Please review and check "no" or "yes" box

Any current problems with your health?		Comments – Additional information	
Stomach / Gastrointestinal / Colon / Rectum	<i>Stomach / Abdominal pain</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Hiatal hernia</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Heartburn / Indigestion</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Nausea / Vomiting</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Diarrhea</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Constipation</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Blood in Stool</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Jaundice / Yellowing of skin</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscles / Bones	<i>Joint pain (where)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Back pain / Disc disease</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Sprain / Strain</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Stiffness / Arthritis</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Artificial joint(s)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Other physical disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Urinary Tract Male / Female Issues Reproduction	<i>Urinary Problems</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Pain with urination</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Kidney Problems / Kidney Stones</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Male or Female Specific Problems</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Females - Could you be pregnant?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood / Lymph	<i>Bleeding problems</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Anemia</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Swollen or enlarged glands</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Immunological	<i>Hay fever</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Allergies</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>HIV / Aids</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	<i>Heat / Cold intolerance</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Hyperthyroid / Hypothyroid</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Increased thirst / Diabetes</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Health	<i>Anxiety / Depression</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Psychiatric Care</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<i>Other Concerns</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Signature: _____ Date: _____		Provider Signature: _____ Date & Time: _____	

PT.NO

NAME

DOB

UW Medicine

Harborview Medical Center – UW Medical Center
 Northwest Hospital & Medical Center – University of Washington Physicians
 Seattle, Washington

PATIENT HEALTH HISTORY SURGERY SPECIALTY
PAGE 6 OF 6

U3158

U3158

WHITE - MEDICAL RECORD