SURGERY SPECIALTY PATIENT HEALTH HISTORY

Chief Complaint - Please describe the problem that brings you into the office today:

Allergies

1. Do you have any allergies? ☐Yes ☐No if so, please list

To **Medications?**_____

To **Foods?**_____

2. Are you allergic to **latex?** ☐Yes ☐No

3. Are you allergic to **iodine?** ☐Yes ☐No

Medications

1. Are you taking any pain medications ☐ YES ☐ NO If so, please list all:

Pain Medications	Dose	Times per day	Reason for taking

2. All other Medications	Dose	Times per day	Reason for taking

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

U3158

U3158

WHITE - MEDICAL RECORD

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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 | Benzodiazepines | Cocaine | Hallucinogens | Marijuana | Opioids | IV | Inhaled | Intranasal | Oral

Use/Week 1 | 2 | 3 | 4 | 5 | 10 | 15 | _____ 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	Yes	No	Deep Vein Thrombosis	Yes	No	Pacemaker or Implanted Defibrillator	Yes	No
Alcoholism	Yes	No	Diabetes Melitus	Yes	No	Pancreatitis	Yes	No
Anal Fissure	Yes	No	Diverticulitis	Yes	No	Pulmonary Arterial Hypertension	Yes	No
Arythmia	Yes	No	Emphysema	Yes	No	Pulmonary Embolism	Yes	No
Barrets Esophagus	Yes	No	Fibrocystic Breast	Yes	No	Pulmonary Hypertension	Yes	No
Breast Mass	Yes	No	GI Disease	Yes	No	Significant Trauma or Injury	Yes	No
Burn Injury	Yes	No	Groin Hernia	Yes	No	TIA	Yes	No
Cancer	Yes	No	Hemangioma	Yes	No	Ventral or Incisional Hernia	Yes	No
Cholelithiasis	Yes	No	Hiatal Hernia	Yes	No	Wound Dehiscence	Yes	No
Cirrhosis	Yes	No	Liver Disease	Yes	No	Wound Infection	Yes	No
Colon Cancer	Yes	No	Liver Mass	Yes	No	Other (please specify below)	Yes	No
Colon Polyps	Yes	No	Obesity	Yes	No			
Cardiovascular Disease	Yes	No	Obstructive Sleep Apnea	Yes	No			

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

General Medical History

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

No Medical Problems	Yes	No	CHF	Yes	No	Heart Attack	Yes	No	Musculoskeletal	Yes	No
Allergies	Yes	No	COPD	Yes	No	Heart Murmur	Yes	No	Osteoporosis	Yes	No
Anemia	Yes	No	Depression	Yes	No	Hepatitis	Yes	No	PPD	Yes	No
Anesthesia Problems	Yes	No	Diabetes Type 1	Yes	No	HIV	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Diabetes Type 2	Yes	No	Hypertension	Yes	No	Stroke	Yes	No
Arthritis	Yes	No	GERD	Yes	No	Insomnia	Yes	No	Substance Abuse	Yes	No
Asthma	Yes	No	Glaucoma	Yes	No	Kidney Disease	Yes	No	Thyroid Disorder	Yes	No
Bleeding/Clotting Disorder	Yes	No	GYN	Yes	No	Lipid/Cholesterol	Yes	No	Tuberculosis	Yes	No
Blood Transfusion	Yes	No	Headaches	Yes	No	Lung Disease	Yes	No	Other (Please list below)	Yes	No
Cardiovascular Disease	Yes	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	Yes	No	Cholecystectomy	Yes	No	Hernia Repair	Yes	No	Splenectomy	Yes	No
Adrenalectomy	Yes	No	Colonoscopy	Yes	No	Joint Replacement	Yes	No	Thyroidectomy	Yes	No
Anorectal Surgery	Yes	No	Colon Resection	Yes	No	Laparotomy	Yes	No	Tubal Ligation	Yes	No
Anti-Reflux Surgery	Yes	No	Cosmetic Surgery	Yes	No	Liver Resection	Yes	No	Valve Replacement	Yes	No
Appendectomy	Yes	No	Esophageal Myotomy	Yes	No	Pancreas Resection	Yes	No	Vasectomy	Yes	No
Bariatric Surgery	Yes	No	Hemorrhoidectomy	Yes	No	Prostate	Yes	No	Other (Please list below)	Yes	No
CABG	Yes	No	Hysterectomy	Yes	No	Small Bowel Resection	Yes	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

Family History: Check all that apply to you and your family members

	PERSONAL HISTORY	FAMILY HISTORY	
Illnesses:	***You***	***Family***	***Which family member(s)***
Alcoholism	☐	☐	
Allergic/Atopic Disease	☐	☐	
Asthma	☐	☐	
Bleeding Disorder	☐	☐	
Cancer	☐	☐	
Coronary Artery Disease	☐	☐	
Diabetes	☐	☐	
Heart Failure	☐	☐	
Heart Murmur	☐	☐	
Hyperlipidemia	☐	☐	
Hypertension	☐	☐	
Liver Disease	☐	☐	
Migraine Headaches	☐	☐	
Myocardial Infraction	☐	☐	
Obesity	☐	☐	
Osteoporosis	☐	☐	
Renal Disease	☐	☐	
Rheumatoid Arthritis	☐	☐	
Seizure	☐	☐	
Stroke	☐	☐	
Thyroid Disease	☐	☐	
Other (please specify)	☐	☐	

If you have other significant family history, please specify:

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*	☐ *Yes* ☐ *No*	Current Height: _____ Weight: _____ lbs
	Fatigue / Trouble sleeping	☐ *Yes* ☐ *No*	
	Fever / Chills / Night sweats	☐ *Yes* ☐ *No*	
	Anesthesia Problems (self)	☐ *Yes* ☐ *No*	
	Anesthesia Problems (family member)	☐ *Yes* ☐ *No*	
Ear / Nose / Mouth / Throat	*Hearing Loss / Hearing Aid*	☐ *Yes* ☐ *No*	
	Ear Problems	☐ *Yes* ☐ *No*	
	Nose Problems	☐ *Yes* ☐ *No*	
	Mouth or Throat Problems	☐ *Yes* ☐ *No*	
	Nose bleeds / Sinus Problems	☐ *Yes* ☐ *No*	
	Dental Problems / Dentures	☐ *Yes* ☐ *No*	
	Loose or Missing Tooth / Teeth	☐ *Yes* ☐ *No*	
Eye	*Wear glasses / contacts*	☐ *Yes* ☐ *No*	
	Eye problems	☐ *Yes* ☐ *No*	
	Yellowing of white part of the eyes	☐ *Yes* ☐ *No*	
Neurology	*Problems with vision*	☐ *Yes* ☐ *No*	
	Headaches / Dizziness	☐ *Yes* ☐ *No*	
	Seizures	☐ *Yes* ☐ *No*	
	Fainting / Unconsciousness	☐ *Yes* ☐ *No*	
	Numbness / Tingling / Weakness	☐ *Yes* ☐ *No*	
Heart	*Chest Pain*	☐ *Yes* ☐ *No*	
	Heart Murmur	☐ *Yes* ☐ *No*	
	High Blood Pressure	☐ *Yes* ☐ *No*	
	Recent Heart Attack / MI	☐ *Yes* ☐ *No*	
	Artificial Heart Valve(s)	☐ *Yes* ☐ *No*	
	Able to walk two flights of stairs	☐ *Yes* ☐ *No*	
Lung	*Shortness of breath (day or night)*	☐ *Yes* ☐ *No*	
	Asthma	☐ *Yes* ☐ *No*	
	Sleep Apnea / Snoring	☐ *Yes* ☐ *No*	
	Difficulty sleeping	☐ *Yes* ☐ *No*	
	Lung problems	☐ *Yes* ☐ *No*	
	Recent cold or cough	☐ *Yes* ☐ *No*	
Skin	*Masses / Bumps / Lumps*	☐ *Yes* ☐ *No*	
	Rashes	☐ *Yes* ☐ *No*	
	Lesions/ Cuts /Scrapes	☐ *Yes* ☐ *No*	
	Wounds / Blisters	☐ *Yes* ☐ *No*	

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	*Stomach / Abdominal pain*	☐ *Yes* ☐ *No*	
	Hiatal hernia	☐ *Yes* ☐ *No*	
	Heartburn / Indigestion	☐ *Yes* ☐ *No*	
	Nausea / Vomiting	☐ *Yes* ☐ *No*	
	Diarrhea	☐ *Yes* ☐ *No*	
	Constipation	☐ *Yes* ☐ *No*	
	Blood in Stool	☐ *Yes* ☐ *No*	
	Jaundice / Yellowing of skin	☐ *Yes* ☐ *No*	
	Hepatitis ☐A, ☐B, or ☐C	☐ *Yes* ☐ *No*	
Muscles / Bones	*Joint pain (where)*	☐ *Yes* ☐ *No*	
	Back pain /Disc disease	☐ *Yes* ☐ *No*	
	Sprain / Strain	☐ *Yes* ☐ *No*	
	Stiffness / Arthritis	☐ *Yes* ☐ *No*	
	Artificial joint(s)	☐ *Yes* ☐ *No*	
	Other physical disability	☐ *Yes* ☐ *No*	
Urinary Tract	*Urinary Problems*	☐ *Yes* ☐ *No*	
	Pain with urination	☐ *Yes* ☐ *No*	
	Kidney Problems / Kidney Stones	☐ *Yes* ☐ *No*	
Male / Female Issues Reproduction	*Male or Female Specific Problems*	☐ *Yes* ☐ *No*	
	***Females** - Could you be pregnant?*	☐ *Yes* ☐ *No*	
Blood / Lymph	*Bleeding problems*	☐ *Yes* ☐ *No*	
	Anemia	☐ *Yes* ☐ *No*	
	Swollen or enlarged glands	☐ *Yes* ☐ *No*	
Immunological	*Hay fever*	☐ *Yes* ☐ *No*	
	Allergies	☐ *Yes* ☐ *No*	
	HIV / Aids	☐ *Yes* ☐ *No*	
Endocrine	*Heat / Cold intolerance*	☐ *Yes* ☐ *No*	
	Hyperthyroid / Hypothyroid	☐ *Yes* ☐ *No*	
	Increased thirst / Diabetes	☐ *Yes* ☐ *No*	
Mental Health	*Anxiety / Depression*	☐ *Yes* ☐ *No*	
	Psychiatric Care	☐ *Yes* ☐ *No*	
	Other Concerns	☐ *Yes* ☐ *No*	
Patient Signature:	Date:	Provider Signature:	Date & Time:

PT.NO

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