Greater Baltimore Center for Minimally Invasive and Endocrine Surgery

Joel A. Turner, M.D., F.A.C.S.
William A. Scovill, M.D., Emeritus.

New Patient Health History Form

Name_____ Primary Care MD_____

Occupation_____ Referring MD_____

Marital Status_____ Date of Birth_____

Chief medical complaint_____

_____

_____

Allergies to any medications_____

Previous operations_____

_____

Past medical history_____

_____

Smoking history_____Alcohol use history_____

Family history: If any blood relative has suffered any of the following, please circle and indicate which relative.

Diabetes_____ Stroke_____

Bleeds Easily_____ Hypertension_____

Heart Disease_____ Cancer_____

(Please go to next page)

Please read through the following list and circle any problem you have had or currently have:

General:	Weight loss Fevers Night sweats Chills
Skin	Rash Skin cancer Melanoma
Breasts	Pain Nipple discharge Masses Infections
Eyes	Vision problems Glaucoma
Ear/Nose/Throat	Hard of hearing Ringing in ears Ear infections Hoarseness Sore throat Voice changes Throat polyps
Respiratory	Wheezing Coughing Asthma TB Pneumonia Shortness of breath
Cardiovascular	High blood pressure Palpitations Heart attack Murmer Difficulty breathing when lying down Waking up shortness of breath
Gastrointestinal	Difficulty swallowing Nausea Vomiting Diarrhea Constipation Bloody stools Black stools Change in bowel habits Heartburn Abdominal pain Inflammatory bowel disease Colitis Ulcers Hemorrhoids Jaundice Hepatitis Diverticulitis
Genitourinary	Burning on urination Blood/air/stool in urine Impotence Prostate problems Kidney stones Sexually transmitted disease Menstrual problems
Musculoskeletal	Broken bones Sprains Arthritis Swollen joints Osteoporosis
Neurologic	Stroke Seizures Fainting spells Migranes Unable to speak Paralysis Fluid in one eye Memory lapse
Psychologic	Depression Panic attacks Anxiety Hearing voices
Endocrine	Diabetes Thyroid problems Goiter Calcium problems
Immunologic	Frequent infections Allergies HIV infection
Hematologic	Enlarged spleen Frequent nosebleeds Easy bruising Blood clots Painful or swollen lymph nodes

PATIENT SIGNATURE:_____ REVIEWED ON: