SURRY MEDICAL SPECIALISTS
a department of Northern Hospital

PATIENT HISTORY

PATIENT NAME: _____ DATE:_____/_____/_____

PATIENT DATE OF BIRTH: _____/_____/_____

REASON FOR TODAY'S VISIT? _____

Past medical history

Illnesses/conditions – please check the box next to any of the illnesses below that you have had or currently have. **Please check all that apply**.

		Date/Details			Date/Details
Abnormal Pap Smear/Periods	☐ Yes	_____	Hepatitis	☐ Yes	_____
Acid Reflux (chronic heartburn)	☐ Yes	_____	Hernia	☐ Yes	_____
Atrial Fibrillation	☐ Yes	_____	High Blood Pressure	☐ Yes	_____
Alcohol Abuse	☐ Yes	_____	High Cholesterol	☐ Yes	_____
Allergies-Seasonal/Hay Fever	☐ Yes	_____	Hyperthyroidism	☐ Yes	_____
Allergy Testing	☐ Yes	_____	Hypothyroidism	☐ Yes	_____
Anemia	☐ Yes	_____	Irregular Heart Beat	☐ Yes	_____
Asthma	☐ Yes	_____	Kidney Stones	☐ Yes	_____
Arthritis	☐ Yes	_____	Liver Disease	☐ Yes	_____
Asbestos Exposure	☐ Yes	_____	Mental Disorder	☐ Yes	_____
Back Pain	☐ Yes	_____	Nasal Polyp	☐ Yes	_____
Bleeding Ulcer	☐ Yes	_____	Osteoporosis	☐ Yes	_____
Blood Transfusions	☐ Yes	_____	Oxygen Use	☐ Yes	_____
Breast Lump	☐ Yes	_____	Peripheral Neuropathy	☐ Yes	_____
Broken Bones	☐ Yes	_____	Pleurisy	☐ Yes	_____
Bronchitis	☐ Yes	_____	Pneumonia	☐ Yes	_____
Cancer (specify type)	☐ Yes	_____	Prostate Disease	☐ Yes	_____
Cataract	☐ Yes	_____	Rheumatic Fever	☐ Yes	_____
Chest Pain	☐ Yes	_____	Sinus Infection	☐ Yes	_____
Congestive Heart Failure	☐ Yes	_____	Skin Disease	☐ Yes	_____
COPD	☐ Yes	_____	Smokeless Tobacco/Snuff Use	☐ Yes	_____
Coronary Artery Disease	☐ Yes	_____	Smoking/Tobacco Abuse	☐ Yes	_____
Diabetes (Type I or II)	☐ Yes	_____	Stroke	☐ Yes	_____
Emphysema	☐ Yes	_____	Thrombophlebitis (blood clot)	☐ Yes	_____
Gall Bladder Disease	☐ Yes	_____	Thyroid Disease	☐ Yes	_____
Gastric Ulcer	☐ Yes	_____	Tonsillitis	☐ Yes	_____
Gastric Bleeding	☐ Yes	_____	Tuberculosis	☐ Yes	_____
Heart Attack	☐ Yes	_____	Ulcer	☐ Yes	_____
Heart Disease	☐ Yes	_____	Urinary Infection	☐ Yes	_____
Heart Murmur	☐ Yes	_____	Venereal Disease	☐ Yes	_____

Other not listed:

_____

_____

Past Surgical History (check all that apply)

	Date/Details		Date/Details
Abdominal Aneurysm Repair	☐ Yes _____	Gallbladder Surgery	☐ Yes _____
Adenoidectomy	☐ Yes _____	Heart Surgery	☐ Yes _____
Appendectomy	☐ Yes _____	Hernia Repair	☐ Yes _____
Angioplasty	☐ Yes _____	Hysterectomy	☐ Yes _____
Back Surgery	☐ Yes _____	Kidney Surgery	☐ Yes _____
Breast Surgery	☐ Yes _____	Lung Surgery	☐ Yes _____
Cardiac Ablation	☐ Yes _____	Open Heart Surgery	☐ Yes _____
Cardiac Stent Insertion	☐ Yes _____	Orthopedic/Bone Surgery	☐ Yes _____
Carotid Endarterectomy	☐ Yes _____	Pacemaker Implantation	☐ Yes _____
Cataract Removal	☐ Yes _____	Sinus Surgery	☐ Yes _____
Colon Surgery	☐ Yes _____	Thyroid Operation	☐ Yes _____
Defibrillator Placement	☐ Yes _____	Tonsillectomy	☐ Yes _____

Other not listed:

_____

_____

Medications (Prescription and Non-Prescription)

Please list all the medications you are taking, including other-the-counter drugs and vitamins.

_____

_____

_____

_____

Allergies

☐ No known Drug Allergies ☐ No known other allergies

If you do have allergies:

☐ Drug Allergies: _____

☐ Food Allergies: _____

☐ Environmental (such as dust, tree pollen, etc.) _____

_____

Family Medical History

Has anyone in your **IMMEDIATE** family (father, mother, sibling, grandparent, children) been diagnosed with any of the following conditions?

	Relationship		Relationship
Asthma	☐ Yes _____	Heart Disease	☐ Yes _____
Cancer-type? _____	☐ Yes _____	High Blood Pressure	☐ Yes _____
Bleeding Disorder	☐ Yes _____	Stroke	☐ Yes _____
Breast Cancer	☐ Yes _____	Thyroid Disease	☐ Yes _____
COPD/Chronic Lung Disease	☐ Yes _____	Tuberculosis	☐ Yes _____
Diabetes	☐ Yes _____		

Other not listed:

_____

_____

Systems Review

Please **MARK** the box next to ANY of the following symptoms or problems you currently have or recently had:

General

- ☐ Appetite Loss
- ☐ Fever/Chills
- ☐ Weight Gain
- ☐ Weight Loss (without dieting)
- ☐ Decline in Activity Tolerance
- ☐ Fatigue
- ☐ Night Sweats

Skin

- ☐ Change in Mole or Wart
- ☐ Itching
- ☐ Boil
- ☐ Rash

Eyes/Ears/Nose/Throat

- ☐ Blurred Vision
- ☐ Visual Loss
- ☐ Nosebleed
- ☐ Seasonal allergies
- ☐ Oral (Mouth) Ulcers
- ☐ Voice Changes
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Choking Sensation

Neck

- ☐ Neck Pain
- ☐ Swollen Glands

Cardiovascular

- ☐ Chest Pain
- ☐ Elevated Blood Pressure
- ☐ Leg Pain
- ☐ Swelling of Extremities
- ☐ Near Fainting or Fainting
- ☐ Difficulty Breathing Lying Down
- ☐ Leg Swelling
- ☐ Phlebitis
- ☐ Calf Cramps
- ☐ Heart Stent
- ☐ Palpitations

Respiratory

- ☐ Cough
- ☐ Shortness of Breath with Exertion
- ☐ Wheezing
- ☐ Recent Respiratory Infection

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Indigestion
- ☐ Difficulty Swallowing
- ☐ Appetite Changes
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Black Tarry Stool
- ☐ Nausea / Vomiting

Genitourinary

- ☐ Blood in Urine
- ☐ Penile Lesions
- ☐ Excessive Urination at Night
- ☐ Pain with Urination
- ☐ Change in Urinary Stream
- ☐ Testicular Mass
- ☐ Urinary Frequency
- ☐ Kidney Stones
- ☐ Testicular Pain
- ☐ Urinary Urgency

Musculoskeletal

- ☐ Arthritis
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Muscle Aches

Neurology

- ☐ Decreased Memory
- ☐ Headaches
- ☐ Stops Breathing at Night
- ☐ Excessive Daytime Sleepiness
- ☐ Seizures
- ☐ Stroke
- ☐ Fainting
- ☐ Snoring
- ☐ Trouble Walking

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mood Changes

Endocrine

- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Heat Intolerance
- ☐ Thyroid problems

Hematology

- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Excessive Bleeding