NORTHERN MEDICAL GROUP
GENERAL SURGERY

Northern Medical Group General Surgery Patient History Form

Name:_____

Past Medical History- Have you ever had any of the following?

	Yes	No	Details
Arthritis			
Asthma			
Bleeding Problem			
Cancer (Please list type)			
COPD			
Diabetes			
Fibromyalgia			
Gout			
Heart Disease			
Hepatitis			
High Blood Pressure			
HIV			
Inheritated Illness			
Problems with Anesthesia			
Seizures			
Sleep Apnea			
Sexually Transmitted Disease			
Thyroid Problems			

Past Surgical History: Please any surgeries that you have had.

_____
_____
_____
_____
_____
_____

Medications: Please list all prescription and over the counter medications you take. Please list name of medication,dose and how you take it.

_____
_____
_____
_____
_____
_____
_____

Allergies: Please list anything you have had an allergic reaction to.
Medications:_____
_____
Food:_____
Enviromental:_____

Family Medical History- List illness and relationship to you.

_____
_____
_____

Social History:
1. Do you have a history of abuse or domestic violence?_____
2. Are you currently a victim of abuse or domestic violence?_____
3. When was your last visit with your family doctor?_____
4. What is your preferred language?_____
5. Do you use alcohol? _____How Often?_____
6. Tobacco Use- Please circle one- Never Former Current Everyday Current Sometimes
7. Do you have any Advances Directives? (Living Will,Healthcare POA,Do Not Resuscitate)
If so please list: _____
8. Have you had a pneumonia vaccine?_____
9. Have you had a flu shot/vaccine?_____

1. Reason for todays visit:_____
2. How long have you had this problem?
3. Do you have pain?_____ Location_____Rating_____out of 10
4. When does the problem occur?_____
5. Do you have other symptoms with the problem?_____
_____

Review of Systems:	Yes	No	Details
Have you had:			
Fever			
Weight Loss			
Fatigue			
Loss of appetite			
Weakness			
Eye problems			
Changes in vision			
Hoarse			
Hearing loss			

Continued…

Review of Systems:	Yes	No	Details
Chest pain			
Cardiac murmurs			
Irregular heart beats			
Swelling			
Shortness of breath			
Cough			
Coughing up blood			
Heartburn			
Problems swallowing			
Nausea			
Vomiting			
Diarrhea			
Constipation			
Abdominal pain			
Blood in stool			
Hemorrhoids			
Frequent urination			
Pain on urination			
Rash or sores			
Changes to moles			
Numbness or tingling			
Seizures			
Back pain			
Joint pain			
Muscle pain			
Joint swelling			
Muscle weakness			
Anxiety			
Depression			
Trouble sleeping			
Easy bleeding			
Easy bruising			
Enlarge lymph nodes			
Slow healing			
Frequent illness			
Hives			