Gomez Surgical

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PATIENT HISTORY FORM

Name: _____ Date: _____

Referring Physician: _____ Date of Birth: _____

Reason for Visit: _____

Past Medical History: Please check if you or your family has ever had any of the following:

Illness or Condition	You	Family	Illness or Condition	You	Family
Ulcerative Colitis or Crohn's Disease			Tuberculosis		
Ulcer			High Blood Pressure		
Colon Polyps or Colon Cancer			High Cholesterol		
Liver Disease			Diabetes		
Pancreatic Disease			Thyroid Disease		
Bleeding Disorder			Kidney Disease		
Have you ever had a blood transfusion?			Seizures		
Lung Disease			Psychiatric Disorder		
Heart Disease			Depression		

Date of last colonoscopy: _____ Hepatitis A Vaccine: _____ Hepatitis B Vaccine: _____

Number of Pregnancies: _____ Number of Live Births: _____ Currently using contraception? Yes ☐ No ☐

Please list all surgeries and recent hospitalizations:

Date	Reason for Surgery or Hospitalization

Family History:

Relative	Age	Living	Deceased	Disease or Cause of Death
Father				
Mother				
Siblings				

Social History:

Marital Status: Single ☐ Divorced ☐ Married ☐ Widow/Widower ☐ Other ☐

Do you smoke? Yes ☐ No ☐ If yes, how many packs per day? _____

Did you smoke? Yes ☐ No ☐ If yes, when did you quit? _____

Do you drink alcohol? Yes ☐ No ☐ If yes, indicate on average how much, and check day, week or month.

_____ Beer(s) per: Day ☐ Week ☐ Month ☐

_____ Glass(es) of wine per: Day ☐ Week ☐ Month ☐

_____ Mixed drink(s) per: Day ☐ Week ☐ Month ☐

Did you previously drink heavily? Yes ☐ No ☐ For how long did you drink heavily? _____

Do you or have you ever used street drugs? Yes ☐ No ☐ Do you have tattoos? Yes ☐ No ☐

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Do you have any other problems you want to discuss? Yes ☐ No ☐

Medications: Please list all of your medications, including over-the-counter medications (i.e. aspirin, vitamins). If you need additional space, please bring a list to your appointment.

Medication Name	Dosage (i.e., 50 mg)	Number of Times Per Day

Allergies: Please list all allergies including medications, food, and environmental:

Review of Systems: Please check any of the conditions that represent a **SIGNIFICANT** problem for you:

General	(√)	Gastrointestinal	(√)	Musculoskeletal	(√)
Fever or chills		Abdominal pain		Broken bones	
Night sweats		Nausea and vomiting		Joint replacement surgery	
Recent weight changes		Heartburn or indigestion		Gout	
Eyes	(√)	Gallbladder problems		Arthritis	
Glasses or contacts		Trouble swallowing		Bone or joint pain	
Glaucoma		Loss of appetite		**Endocrine**	(√)
Other eye problems		Diarrhea		Heat or cold intolerance	
Ears, Nose, Mouth	(√)	Constipation		Hot flashes	
Nose bleeds		Rectal pain		Excessive thirst	
Sinus problems		Hemorrhoids		Flushing	
Earache		Blood in stools		Changes in body hair	
Hearing loss		Tarry stools		**Skin**	(√)
Dentures		**Genitourinary**	(√)	Rash, dryness or itching	
Respiratory	(√)	Painful urination		Jaundice	
Cough		Kidney stones		Easy bruising	
Wheezing		Frequency at night		Psoriasis or eczema	
Shortness of breath		Urgency		Pigment changes	
Asthma		Slow or small stream		**Neurological**	(√)
Cardiovascular	(√)	Blood in urine		Numbness	
Chest pain		Leaking of urine		Headaches	
Heart palpitations		Poor bladder emptying		Stroke	
Irregular heart beat		Recurrent bladder infections		Dizziness	
Heart attack or failure		Menstrual problems		Paralysis	
Heart murmur		Abnormal vaginal bleeding		**Psychiatric**	(√)
Heart valve problems				Depression	