



OREGON SURGICAL SPECIALISTS, P.C.  
**MEDICAL HISTORY QUESTIONNAIRE**

DATE \_\_\_\_\_ FULL NAME \_\_\_\_\_

Sex: M F Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

What is the chief reason that you are consulting a surgeon? \_\_\_\_\_

**Please circle any medical diseases for which you are now being treated now, have been treated in the past, or for which you have been admitted to the hospital:**

- |                     |                                   |
|---------------------|-----------------------------------|
| High blood pressure | Diabetes                          |
| Heart attack        | Vascular disease                  |
| Angina              | Hyperlipidemia / High cholesterol |
| Chest pain          | Arthritis – Rheumatoid -- Osteo   |
| Lung disease        | Atrial Fibrillation               |
| Other _____         | Aneurysm                          |

**FEMALES:** Age started menstruating? \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of deliveries \_\_\_\_\_  
# of c-sections \_\_\_\_\_ Date of last normal period \_\_\_\_\_ Hormone therapy \_\_\_\_\_

**OPERATIONS:**

<u>SURGERY NAME</u>	<u>DATE</u>	<u>HOSPITAL, CITY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES TO MEDICATIONS:**

<u>MEDICATION NAME</u>	<u>TYPE OF RESPONSE</u>
_____	_____
_____	_____

Physician Review \_\_\_\_\_ Date \_\_\_\_\_

Have you ever had any anesthetic complications? \_\_\_\_\_

Have you ever had a life-threatening reaction to medication? \_\_\_\_\_

**FAMILY HISTORY:**

	<u>LIVING</u>	<u>AGE</u>	<u>CHIEF MEDICAL DISEASES</u>
Mother	Y N	_____	_____
Father	Y N	_____	_____
Brother	Y N	_____	_____
Brother	Y N	_____	_____
Sister	Y N	_____	_____
Sister	Y N	_____	_____

Circle diseases that tend to run in your family:

Diabetes

High blood pressure

Heart attacks

Strokes

Cancer

Bleeding disorders

Other \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke? Y N Packs per day? \_\_\_\_\_ How long? \_\_\_\_\_ When did you stop? \_\_\_\_\_

Do you drink alcohol? Y N Type? \_\_\_\_\_ How much? \_\_\_\_\_

How often? \_\_\_\_\_

What type of work do you do, or have you done most of your life? \_\_\_\_\_

**Please circle if you have the following current symptoms or problems:**

**HEENT**

Trouble with your eyes

Seasonal allergies

**CARDIOVASCULAR**

Chest pain on exertion

Chest tightness on exertion

Angina

Chronic ankle swelling

Difficulty breathing when lying flat

Fainting spells

**PULMONARY**

Shortness of breath on exertion

Recurrent lung infections

Cough up blood

**GI**

Significant weight gain

Significant weight loss

Frequent nausea

Frequent vomiting

Frequent diarrhea

Frequent constipation

Change in bowel habits

Change in stool size

Black tarry stools

Blood in stools

**GI, CONT.**

Hemorrhoids

Hernias

Peptic ulcer disease

Vomiting blood

**GU**

Urinary incontinence

Burning w/ urination

**MUSCULOSKELETAL**

Chronic back pain

**SKIN**

Concerning skin lesions

**NEUROLOGIC**

Seizures

CVA (cerebrovascular accident)

TIA (stroke)

Loss of strength or sensation on one side

**ENDOCRINOLOGY**

Thyroid problems

Diabetes

**HEMATOLOGY**

Bleeding problems

Blood clots