Methodist The Methodist Hospital

Department of Surgery

Patient Medical & Surgical History Form

Dear Patient,

Welcome to the Methodist Department of Surgery. We thank you for allowing us to participate in your care.

On the following pages we would like you to provide us with some information about your health history. The purpose of this form is to gather important health information so that we can optimize communication between you, your referring physician, and your Methodist physician. This form will become part of the protected (confidential) health information in your medical record. Please be as detailed as possible. The data you provide will be reviewed by your physician and discussed with you during your clinic visit.

Referring Physician______________________________ Contact Number_____________________________

Reason for your visit____

Occupation____

List of current physicians/referring doctors:

Physician Name	Area of Specialty	Address	Phone	FAX

Past Medical History-Please check all that apply, note date of onset.

- [ ] Unremarkable
- [ ] Anemia *
- [ ] Anxiety *
- [ ] Asthma *
- [ ] Atrial Fibrillation *
- [ ] Auto-Immune Disease *
- [ ] Biliary Cirrhosis *
- [ ] Bipolar Disorder *
- [ ] Blood Transfusions *
- [ ] Breast Disease *
- [ ] Cancer *
- [ ] Cerebrovascular Disease *
- [ ] Chronic Renal Failure *
- [ ] C O P D *
- [ ] Congenital Heart Disease *
- [ ] Coronary Heart Disease*
- [ ] Crohn's Disease *
- [ ] C V A-Stroke *
- [ ] Dementia *
- [ ] Depression *
- [ ] Diabetes*
- [ ] Diabetic Complications*
- [ ] Diverticulosis*
- [ ] D V T *
- [ ] G E R D *
- [ ] Gout*
- [ ] G I Bleed *
- [ ] Heart-ASCVD*
- [ ] Heart-CHF*
- [ ] Hepatitis A *
- [ ] Hepatitis B *
- [ ] Hepatitis C *
- [ ] HIV *
- [ ] Hyperlipidemia *
- [ ] Hypertension *
- [ ] Jaundice as newborn *
- [ ] Jaundice in childhood *
- [ ] Liver Disease *
- [ ] Myocardial Infarction *
- [ ] Obesity *
- [ ] Osteoarthritis *
- [ ] P U D *
- [ ] P V D *
- [ ] Renal Disease *
- [ ] Rheumatoid Arthritis *
- [ ] Seizure Disorder *
- [ ] Substance Abuse *
- [ ] Thyroid Disease *
- [ ] Tuberculosis *
- [ ] Valvular Heart Disease *
- [ ] Weight Loss *

Please list any medical conditions and the date of onset that are not listed above.

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Past Surgical History-Please check all that apply.
***Please include all prior endoscopy and needle biopsy information that may relate to your current health problem.*

☐ Unremarkable	☐ Cholecystectomy	☐ Nephrectomy:Transplant	☐ Anesthesia Prob-No
☐ Abd Surg-type	☐ Colon Resection	☐ Pacemaker	☐ Anesthesia Prob-Yes
☐ Amputation	☐ Craniotomy	☐ Parathyroidectomy	☐ Surgical Complications-No
☐ AV Fistula Creation	☐ Gastric Bypass	☐ Pneumonectomy	☐ Surgical Complications-Yes
☐ AV Graft	☐ Hemorrhoidectomy	☐ PTCA	☐ Post-op delirium
☐ Aortic Valve Replacement	☐ Hip Replacement	☐ R A-F Bypass	
☐ Appendectomy	☐ Interventional pain procedures	☐ Rotator Cuff Repair	
☐ B A-F Bypass	☐ Knee Arthroscopy	☐ TAH w/ BSO	
☐ Back surgery	☐ Knee Replacement	☐ TAH	
☐ Breast Surgery	☐ Kyphoplasty	☐ Tonsillectomy	
☐ Bronchoscopy	☐ L A-F Bypass	☐ Tunneled Dialysis Catheter	
☐ CABG	☐ Lumpectomy	☐ U P P P	
☐ Carotid Endarterectomy	☐ Mastectomy	☐ Urinary incontinence surgery	
☐ Carpal Tunnel	☐ Mitral Valve Replace	☐ Vertebroplasty	
☐ Cataract Extraction	☐ Nephrectomy:Native		

Please list any previous surgeries not noted above and the year the surgery took place.

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Review of Systems: Please check any recent symptoms you may have. If you do not have these symptoms, please leave the box blank.

CONSTITUTIONAL:	**Gastrointestinal**:	**Skin:**
☐fever	☐nausea	☐rash
☐chills	☐vomiting	☐itching
☐sweats	☐diarrhea	☐dryness
☐anorexia (loss of appetite)	☐constipation	☐suspicious lesions
☐fatigue	☐change in bowel habits	☐hair loss
☐weakness	☐abdominal pain	☐injection site reaction
☐malaise (low energy)	☐melena (dark blood per rectum)	
☐weight loss	☐hematochezia (red blood per rectum)	
☐sleep disorder	☐jaundice (turning yellow)	**Neurology:**
☐tired all the time	☐increased gas	☐numb/tingling
	☐bloating	☐paralysis (loss of function)
	☐indigestion/heartburn	☐paresthesias (loss of feeling)
EYES:	☐dysphagia (difficulty swallowing)	☐seizures
☐blurring	☐odynophagia (pain with swallowing)	☐tremors
☐irritation	☐decreased appetite	☐vertigo
☐vision loss	☐taste change	☐dizziness
☐eye pain		☐transient blindness
☐photophobia (sensitive to light)		☐frequent falls
☐sore eyes		☐headaches
☐vision change		☐difficulty walking
☐icteric (yellow sclera)		☐history of TIA's (mini-stroke)
		☐prior CVA (stroke)

ENT:
☐earache
☐tinnitus (ringing)
☐decreased hearing
☐nosebleeds
☐sore throat
☐hoarseness
☐mouth sores

Cardiovascular:
☐chest pain at rest
☐chest pain with exercise
☐palpitations
☐shortness of breath
☐syncope (passing out)
☐dyspnea on exertion
☐orthopnea (difficulty lying flat)
☐PND (waking up short of breath)
☐peripheral edema (ankle swelling)
☐claudication
☐orthostatic symptoms (dizzy when standing)

Respiratory:
☐cough
☐dyspnea at rest
☐hemoptysis (coughing up blood)
☐shortness of breath
☐history of sleep apnea
☐daytime somnolence
☐sneeze

Genitourinary:
(Female)
☐incontinence
☐dysuria (pain with urination)
☐hematuria (blood in urine)
☐urinary frequency
☐amenorrhea (loss of menses)
☐menorrhagia (irregular menses)
☐abnormal vaginal bleeding
☐pelvic pain
☐decreased libido
☐increased urination
(Male)
☐dysuria (pain with urination)
☐hematuria (blood in urine)
☐urinary frequency
☐urinary hesitancy
☐nocturia (waking up to urinate)
☐incontinence
☐increased urination
☐decreased libido
☐erectile dysfunction

Muscluloskeletal:
☐back pain
☐joint pain
☐joint swelling
☐muscle cramps
☐muscle weakness
☐stiffness
☐arthritis
☐muscle aches

Psychology:
☐depression
☐anxiety
☐decreased concentration
☐memory loss
☐suicidal ideation
☐hallucinations
☐paranoia
☐phobia
☐confusion
☐insomnia
☐agitative
☐emotional instability

Endocrine:
☐cold intolerance
☐heat intolerance
☐polydipsia (excessive drinking)
☐polyphagia (excessive eating)
☐polyuria (increased urination)
☐unusual weight change
☐excessive weight change
☐hair loss

Heme/Lymphatic:
☐abnormal bruising
☐bleeding
☐enlarged lymph nodes

Immune/Allergy
☐urticaria (hives)
☐allergic rash
☐hay fever
☐recurrent infections

Further Description of Positive Review of Systems that you checked above:

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Family History: Did any members of your family have any of the diagnosis noted below? If so, what relative had which diagnosis and what was the age of onset?
Stroke/seizure, hypertension, heart attack, diabetes, inflammatory disease, cancer, or anesthesia complications

Relative & Diagnosis	**Age at onset**

Social History:

Who do you live with: ____

What is your most recent occupation: ____________________________________

If you have smoked tobacco,

for how many years___________, how many packs per day___________

If you have regularly consumed alcohol,

for how many years___________, how many drinks per day___________

Do you take any non-prescription herbal medicines or other drugs?

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Other Comments: ____

Allergies: Are you allergic to any medications? If so, please list which medication and your reaction to this medication.

Medication	Reaction

Medications: Please list the name and dosage of any current medications.

Drug Name	Timing

General Health Maintenance (Male):

Test	Date	Result
Colonoscopy		
Upper Endoscopy		
Prostate Screen		

General Health Maintenance (Female):

Test	Date	Result
Colonoscopy		
Endoscopy		
Mammogram		
Pap/GYN exam		
Age at menarche	Age at menopause	
How many pregnancies have you had?	Age at 1st full-term pregnancy?	
Do you have a history of lymphedema/irradiation?		

Attending Physician Attestation:
I have reviewed the health information documented on this form by the patient including the Past Medical History, Review of Systems, Family & Social History, and Medication History.

For the Review of Systems, the following Body Systems were reviewed and all items that were not noted by the patient were confirmed to be negative.
□ Constitutional □ Eyes □ ENT □ CV □ Resp □ GI □ GU □ MS □ Skin □ Neuro □ Psych □ Endocrine □ Heme/Lymph/Immuno

Please refer to the remainder of my clinic note for Chief Complaint, History of Present Illness, Comments on Past Medical History, Assessment, and Treatment Plan.

Print: __________________________________ Sign: _________________________________ Date: _____/____/_____