SOUTH ABILENE
Surgical Associates

Date: _____

Name: _____

DOB: _____

ADULT PATIENT HEALTH HISTORY

PAST SURGICAL HISTORY: ***LIST THE YEAR*** you had any of the following:

_____ Appendectomy _____Gallbladder _____Hernia

_____ Blood Transfusion _____Heart/ Cath _____Tonsillectomy

_____Hysterectomy _____ Tubal/ Vasectomy

Others: _____

_____

_____

_____

_____

FAMILY HISTORY

Blood Relatives	Age if living	Age at Death	Major illness &/or Cause of Death ***(Choose from PAST MEDICAL HISTORY section)***
Mother			
Father			
Brothers #: _____			
Sisters #: _____			
Children #: _____			

HABITS: *DO YOU USE **(OR HAVE YOU EVER USED)** ANY OF THE FOLLOWING*:

Tobacco: ☐ Never ☐ Now ☐ Quit (year) _____; Type Used: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐Smokeless
Amount used per day: _____ How many years?: _____

Alcohol: ☐ Never ☐ Social/Rare ☐ Now ☐ Quit (year): _____; Type used: ☐ Beer ☐ Wine ☐Liquor

Drug Use: ☐ Never ☐ Now ☐ Quit (year) _____; Type: ☐Pot ☐Cocaine ☐IV ☐Pain pills ☐Other: _____

Caffeine: # per day: Coffee (cups): _____ Tea (glasses): _____ Soda (12oz cans): _____

Exercise: ☐ None per week ☐ # of times/week: _____ Type: _____

_____ _____

Patient Signature / Date Completed Physician Signature / Date Reviewed (optional)

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OUTPATIENT HISTORY/REVIEW OF SYSTEMS

If you have any recent trouble with the following issues, check the problem(s) listed.
If you ***DO NOT*** have any of the problem selections, check the "***No Problem***" box.

General:

- ☐ Unusual weight changes
- ☐ Fever
- ☐ Fatigue
- ☐ Weakness
- ☐ Pain
- ☐ NO PROBLEM

Throat:

- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ Swelling
- ☐ NO PROBLEM

Lungs:

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Coughing Blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ NO PROBLEM

Heart & Circulation:

- ☐ Chest pain, tightness, or pressure
- ☐ Irregular heartbeat
- ☐ Fast or Slow heartbeat
- ☐ Ankle swelling
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ NO PROBLEM

Urinary:

- ☐ Frequency of painful urinating
- ☐ Urinating at night
- ☐ Losing control of urine/wetting self
- ☐ Blood in Urine
- ☐ NO PROBLEM

Stomach, Intestines, & Colon:

- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Food intolerance
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Change in bowel Habits
- ☐ Indigestion
- ☐ NO PROBLEM

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Muscles, Joints & Bones:

- ☐ Joint stiffness or pain
- ☐ Backache
- ☐ Muscle pains or cramps
- ☐ Limitation of joint or muscle movement
- ☐ Joint swelling or redness
- ☐ Bone pain
- ☐ NO PROBLEM

Nervous System:

- ☐ Fainting
- ☐ Seizures/Epilepsy
- ☐ Tremors
- ☐ Memory loss
- ☐ Blackouts
- ☐ Paralysis
- ☐ Tingling of part of body
- ☐ Headaches
- ☐ NO PROBLEM

Blood/Allergies:

- ☐ Depression
- ☐ Nervousness
- ☐ Alcohol/Drug abuse
- ☐ NO PROBLEM

Genitals:

Men Only:

- ☐ Groin Swelling
- ☐ Hernias
- ☐ Testicular pain/masses
- ☐ Breast Lump
- ☐ NO PROBLEM

Women Only:

- ☐ Breast Lump
- ☐ NO PROBLEM

_____ Date

_____ Patient or Responsible Party Signature

_____ Doctor's Signature

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ADULT PATIENT HEALTH HISTORY- MEDICATION LIST

CURRENT MEDICATIONS: List all medications that you take routinely or that have been prescribed for you by a doctor ***(Include vitamins, over-the- counter medications, eye drops, herbal medications, etc.)***

MEDICATION	**DOSE**	**HOW OFTEN**	**REASON**

ALLERGIES: ☐ None ☐ Antibiotics ☐ Foods ☐ Inhalants ☐ Insects

☐ Latex ☐ Meds ☐ Pollens ☐ Skins ☐ Transfusions ☐ X-Ray Contrast

Specify: _____

_____

_____ _____

Patient Signature / Date Completed Physician Signature / Date Reviewed (optional)