Patient Name _____ Today's Date _____

REASON FOR TODAY'S VISIT _____

Past Medical History - CHECK ALL THAT APPLY

_____ Hypertension (high blood pressure)
_____ Acute Myocardial Infarction (heart attack)
_____ Atrial fibrillation
_____ Coronary Artery Disease (heart disease)
_____ Stroke
_____ Venous thrombosis (blood clot)
_____ Cancer (type) _____
_____ High cholesterol
_____ Diabetes
_____ Thyroid disorder
_____ Esophageal reflux (GERD)
_____ Seizure Disorder
_____ Asthma
_____ COPD (chronic obstructive pulmonary disease)
_____ Sleep apnea
_____ Osteoporosis
_____ Renal Failure (kidney failure)
_____ Blood disorder
_____ HIV infection
_____ Hepatitis
_____ Personal history of colon polyps
_____ MRSA (Methacillin resistant staph infection)
_____ VRE (Vanco resistant enterococcus infection)
_____ Reaction to radiographic contrast material
_____ Reaction to anesthetics

Social History - CIRCLE ONE

Tobacco use	(Circle one)	Current	Former	Never
(Circle one)	Cigarettes	Chewing Tobacco	Other	_____
Alcohol Use	(Circle one)	Current	Former	Never
Drug Use	(Circle one)	Current	Former	Never
Caffeine Use	(Circle one)	Current	Former	Never

Family History - CHECK ALL THAT APPLY

_____ Family history of Colon Polyps/relationship _____
_____ Family history of Colon Cancer/relationship _____
_____ Family history of Breast Cancer/relationship _____
_____ Heart Disease/relationship _____
_____ Diabetes/relationship _____

Other History (Please list other pertinent medical/social/family history)

_____

_____

_____

Are you ALLERGIC to any Medicines? _____

Are you DIABETIC? YES NO
Are you taking BLOOD THINNERS? YES NO (Coumadin, Plavix, Warfarin, Aspirin)

Past Surgical History - CHECK ALL THAT APPLY

_____ Back Surgery
_____ Hip replacement
_____ Knee replacement
_____ Rotator Cuff Repair

_____ Appendectomy
_____ Gallbladder Surgery
_____ Hernia Repair
_____ Upper EGD
_____ Colonoscopy
_____ Sigmoidoscopy
_____ Colon resection
_____ Colostomy
_____ Ileostomy
_____ Hemorrhoidectomy

_____ Bariatric surgery
_____ Lung surgery
_____ Radiation of thyroid
_____ Thyroid surgery

_____ Heart Valve Replacement
_____ CABG (Heart bypass)
_____ Heart Stent Placement
_____ Cardiac Pacemaker
_____ Cardiac-Defibrilaltor

_____ Nephrectomy (Kidney removal)

_____ **No Past Surgical History**

_____ Breast Surgery
_____ Hysterectomy
_____ Tubal Ligation

_____ Cesarean Section
_____ Prostate Surgery

_____ Carotid Endarterectomy (Carotid artery surgery)
_____ AAA Repair (aortic aneurysm repair
_____ Varicose Vein Ligation

_____ Tonsillectomy
_____ Cataract surgery

Surgical History not listed? _____

Review of Systems - CHECK ALL THAT APPLY

Constitutional
_____ Weight change
_____ Abnormal appetite
_____ Fever
_____ Chills
_____ Tiring easily

Skin
_____ Itching skin

Eyes and Head
_____ Headache
_____ Dizziness
_____ Fainting

Ears, Nose, Throat
_____ Neck pain
_____ Lump or swelling in neck
_____ Hoarseness
_____ Throat pain

Cardiovascular
_____ Chest pain
_____ Fast heart rate
_____ Palpitations

Respiratory
_____ Shortness of breath
_____ Cough
_____ Wheezing

Gastrointestinal
_____ Difficulty swallowing
_____ Heartburn
_____ Nausea
_____ Vomiting
_____ Abdominal pain
_____ Bowel changes
_____ Diarrhea
_____ Constipation
_____ Black stools
_____ Rectal bleeding

Psychiatric
_____ Anxiety
_____ Depression

Current Height

Current Weight

_____ **Other symptoms not listed**? _____

_____

Patient signature _____ **Date** _____

Bryan Physician Network

SURGERY GROUP OF GRAND ISLAND
HEALTH HISTORY

Place Patient Label Here