Name_____ Date of Birth_____

# Patient Medical History & Review of Systems

**Please indicate any personal history below, past or present**

## Constitutional Systems

Recent weight change ☐ No ☐ Yes
Loss / Gain # of pounds_____
Fever ☐ No ☐ Yes
Eye disease or cataracts ☐ No ☐ Yes
Wear glasses/contact lenses ☐ No ☐ Yes
Blurred or double ☐ No ☐ Yes
Glaucoma ☐ No ☐ Yes

## Ears/Nose/Mouth/Throat

Hearing loss or ringing ☐ No ☐ Yes
Chronic sinus problems ☐ No ☐ Yes
Nose bleeds ☐ No ☐ Yes
Sore throat or voice change ☐ No ☐ Yes

## Cardiovascular

Heart murmur ☐ No ☐ Yes
Mitral valve prolapse ☐ No ☐ Yes
Rheumatic fever ☐ No ☐ Yes
High or low blood pressure ☐ No ☐ Yes
On blood pressure medication ☐ No ☐ Yes
Chest pain or angina pectoris in the last 30 days ☐ No ☐ Yes
Palpitation ☐ No ☐ Yes
Congestive Heart Failure ☐ No ☐ Yes
Pacemaker / AICD ☐ No ☐ Yes
Irregular pulse ☐ No ☐ Yes
History of heart attack ☐ No ☐ Yes
When? _____
Swelling of feet, ankles or hands ☐ No ☐ Yes
Heart disease ☐ No ☐ Yes
Coronary angiogram ☐ No ☐ Yes
When? _____
Heart surgery ☐ No ☐ Yes
When? _____
Peripheral Vascular Disease ☐ No ☐ Yes

## Respiratory

Chronic or frequent coughs ☐ No ☐ Yes
Emphysema or COPD ☐ No ☐ Yes
Asthma ☐ No ☐ Yes
Bronchitis ☐ No ☐ Yes
Tuberculosis or positive TB test ☐ No ☐ Yes
Shortness of breath while walking or lying flat ☐ No ☐ Yes
Wheezing ☐ No ☐ Yes
Pneumonia ☐ No ☐ Yes
Spitting up blood ☐ No ☐ Yes
Sleep apnea ☐ No ☐ Yes

## Gastrointestinal

Abdominal Pain ☐ No ☐ Yes
Esophageal Varices ☐ No ☐ Yes
Nausea or vomiting ☐ No ☐ Yes
Frequent diarrhea ☐ No ☐ Yes
Change in bowel movement ☐ No ☐ Yes
Painful bowel movements or constipation ☐ No ☐ Yes
Rectal bleeding or blood in stool ☐ No ☐ Yes
Stomach ulcer ☐ No ☐ Yes
Vomiting blood ☐ No ☐ Yes
History of liver disease ☐ No ☐ Yes
Jaundice ☐ No ☐ Yes
Hepatitis ☐ No ☐ Yes
Hemorrhoids ☐ No ☐ Yes
Date of last colonoscopy _____

## Genitourinary

Frequent Urination ☐ No ☐ Yes
Burning or painful urination ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Change in force of stream when urinating ☐ No ☐ Yes
Incontinence or dribbling ☐ No ☐ Yes
Kidney stones ☐ No ☐ Yes
Males - testicle pain ☐ No ☐ Yes
Males - Date of last PSA? _____
Females - Date of LMP _____
Females - Hysterectomy or tubal ligation? ☐ No ☐ Yes

## Musculoskeletal

Joint pain ☐ No ☐ Yes
Weakness of muscles/joints ☐ No ☐ Yes
Muscle pain or cramps ☐ No ☐ Yes
Back pain ☐ No ☐ Yes
Cold extremities ☐ No ☐ Yes
How far can you walk without pain? _____
Pain while at rest ☐ No ☐ Yes
Arthritis ☐ No ☐ Yes
Hernia ☐ No ☐ Yes

## Integumentary (skin, breast)

Rash or itching ☐ No ☐ Yes
Change in skin color ☐ No ☐ Yes
Varicose veins ☐ No ☐ Yes
Breast pain ☐ No ☐ Yes
Breast lump ☐ No ☐ Yes
Breast discharge ☐ No ☐ Yes
Date of last mammogram? _____

## Psychiatric

Memory Loss or confusion ☐ No ☐ Yes
Nervousness ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Insomnia ☐ No ☐ Yes

## Neurological

Frequent or recurring headaches ☐ No ☐ Yes
Light headed or dizzy ☐ No ☐ Yes
Convulsions or seizures ☐ No ☐ Yes
Numbness/tingling sensation ☐ No ☐ Yes
Tremors ☐ No ☐ Yes
Paralysis ☐ No ☐ Yes
Head injury ☐ No ☐ Yes
Stroke (RIND or TIA) ☐ No ☐ Yes
Migraine headaches ☐ No ☐ Yes
Brain tumor ☐ No ☐ Yes

## Endocrine

Prescription steroid use ☐ No ☐ Yes
Glandular or hormone problems ☐ No ☐ Yes
Excessive thirst or urination ☐ No ☐ Yes
Heat or cold intolerance ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes
on diabetic medication or insulin? ☐ No ☐ Yes
Thyroid disease ☐ No ☐ Yes
Kidney disease ☐ No ☐ Yes
Kidney failure ☐ No ☐ Yes
Hemo Dialysis or CAPD ☐ No ☐ Yes

## Hematologic/Lymphatic

Slow to heal after cuts ☐ No ☐ Yes
Bleeding or bruising tendency ☐ No ☐ Yes
Anemia ☐ No ☐ Yes
Phlebitis or blood clots in legs ☐ No ☐ Yes
Past transfusion-blood/plasma ☐ No ☐ Yes
Enlarged glands ☐ No ☐ Yes
Cancer ☐ No ☐ Yes
Chemo or radiation ☐ No ☐ Yes
HIV+ ☐ No ☐ Yes

Date & location of most recent blood work

_____

Dale & location of most recent EKG

_____

Date & location of most recent chest X-ray

_____

## Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____
Signature of patient (or legal representative and relationship) Date

_____ _____
Physician Signature Date

**List all known past diagnoses and any other pertinent medical history:**

_____

_____

_____

_____

_____

_____

_____

**Previous Surgeries:**

_____

_____

_____

_____

_____

**List all current medications:**

_____

_____

_____

_____

**Allergies:**

_____

_____

_____

_____

**Family history:**

_____

_____

_____

_____

_____

**Social history:**

**Use of alcohol:**

Current ☐ No ☐ Yes if yes, number of drinks/week _____

Past ☐ No ☐ Yes if yes, number of drinks/week _____

**Use of tobacco:**

Current ☐ No ☐ Yes if yes, number of packs/day _____number of years _____

Past ☐ No ☐ Yes if yes, when did you quit? _____

Do you use illegal/street drugs? ☐ No ☐ Yes if yes, what do you use? _____

Do you have a religious affiliation that would affect decisions about your care? ☐ No ☐ Yes

If yes, explain_____

_____

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Please list below any and all individuals (family/friends) that you may want Hartsville Surgical Center, LLP to disclose your protected health record to.

_____

_____

_____

_____

_____

_____

_____

Please print your name, sign and date below

| _____ | _____ | _____ |
|---|---|---|
| Print | Signature | Date |