1801 Hwy 99 North
Suite 2
Ashland OR 97520
PH 541.488.4464
FAX 541.488.3772

Surgical History Questionnaire (Page 1)

Please complete this form as carefully as you can. (both pages, front and back). **It will be made part of your medical record and will, of course, be confidential.**

Date ________ Full Name ______________________________
First Middle Last

Sex: ☐ Male ☐ Female Birthdate ___ / ___ / ___ Age _____

Primary Care Provider ____________________ Referring Dr. ____________________

Chief Complaint:

1. What is the chief reason that you are consulting this surgeon? ____________________
2. When did the problem first start? ____________________

Past Medical History

3. Did you have an unusual childhood diseases, such as rheumatic fever, heart disease, leukemia, kidney disease, hormone disorder, tumors? Circle and explain ____________________
4. Do you bleed excessively or easily, such as after tooth extractions or accidents? ☐ Yes ☐ No
   Have you ever required a transfusion? ☐ Yes ☐ No
   If yes, when? ____________________
   About how many? ____________________

Adult Illnesses

5. Please list medical diseases for which you are now being treated, or for which you have been admitted to the hospital:

	Date of onset or duration
☐ High blood pressure	________
☐ Diabetes	________
☐ Heart Attack	________
☐ Heart Failure	________
☐ Stroke	________
☐ Vascular (blood vessel) Dis.	________
☐ Auto Immune Disorder	________
☐ Cancer (current or past)	________
☐ Hepatitis	________
☐ Other: Explain ________	________

6. **Females**
   a. Pregnancies, how many? ________ Your age at the birth of your first child ________
   b. Deliveries, how many? ________
   c. Did you breast feed? ☐ Yes ☐ No
   d. Miscarriages or abortions ☐ Yes ☐ No How Many? ________
   e. Caesarean Sections, how many? ________
   f. Complications of pregnancy? ________
   g. Date of last normal period? ________
   h. Age of first period? ________
   i. Date of last mammogram? ________

(pages on back)

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Surgical History Questionnaire
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7. **Operations** with dates, and hospital if known

____

____

____

8. **Medications:** Doses and how often taken ______________________________

____

____

Herbals ______________________________

	Medications	Reaction
Allergies to Medications ☐ No ☐ Yes	______	______
	______	______
	______	______

Latex Allergy? ☐ No ☐ Yes Reaction: ______________________________

Family History

		LIVING?	AGE	CHIEF MEDICAL DISEASES
9.	Parents: Mother	☐ Yes ☐ No	______	______
	Father	☐ Yes ☐ No	______	______
10.	Siblings: Brother	☐ Yes ☐ No	______	______
	Brother	☐ Yes ☐ No	______	______
	Brother	☐ Yes ☐ No	______	______
	Sister	☐ Yes ☐ No	______	______
	Sister	☐ Yes ☐ No	______	______
	Sister	☐ Yes ☐ No	______	______

Social History

11. Do you smoke? ☐ Yes ☐ No Cigarettes? ☐ Yes ☐ No Packs per day? ______How Long? ______
    Cigar? ☐ Yes ☐ No Pipe? ☐ Yes ☐ No
    Have you ever smoked? ☐ Yes ☐ No How much? ______When did you stop? ______
12. Do you drink alcohol? ☐ Yes ☐ No Type? ______
    How much? ______ How often? ______
13. Have you ever used any other drugs? ☐ No ☐ Yes What and When? ______
14. What type of work do you do, or have done most of your life? ______
15. Are you ☐ Single ☐ Married ☐ Partnered ☐ Widowed Name of Significant Other: ______

BEAR CREEK
MEDICAL PLAZA

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Surgical History Questionnaire
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Review of Systems (**If yes to following questions, when in recent past? How often?**)

Central Nervous System

16. Do you have seizures? ☐ Yes ☐ No
17. Severe headaches? ☐ Yes ☐ No
18. Temporary changes in vision or hearing? ☐ Yes ☐ No
19. Any temporary loss of strength or sensation on one side? ☐ Yes ☐ No

Cardiovascular (check or explain)

20. Do you have chest pain, chest tightness, or angina on exertion? ☐ Yes ☐ No
    At rest? ☐ Yes ☐ No
    Duration? ______________
21. Chronic ankle swelling? ☐ Yes ☐ No
22. Can you sleep flat in bed? ☐ Yes ☐ No
23. Do you wake up at night short of breath? ☐ Yes ☐ No
24. Do you have frequent dizzy or fainting spells? ☐ Yes ☐ No
25. Do you have palpitations or an irregular heartbeat? ☐ Yes ☐ No
26. Do you take antibiotics for dental procedures? ☐ Yes ☐ No

Respiratory

27. Do you get short of breath on mild exertion? ☐ Yes ☐ No
28. Can you walk two flights of stairs without significant discomfort? ☐ Yes ☐ No
29. Do you have frequent yellow or green sputum? ☐ Yes ☐ No
30. Has there been any change in your voice recently? ☐ Yes ☐ No
31. Do you have frequent or chronic chest pain? ☐ Yes ☐ No
32. Do you cough up blood? ☐ Yes ☐ No
33. Have you ever had phlebitis, or blood clots in your legs? ☐ Yes ☐ No

Gastrointestinal

34. Have you lost or gained weight over the last several months? ☐ Yes ☐ No
    ☐ Lost ☐ Gained How much? ______________________
35. Frequent nausea, vomiting, diarrhea, or constipation ☐ Yes ☐ No
36. Change in bowel habits or stool size? ☐ Yes ☐ No
37. Black tarry stools? ☐ Yes ☐ No
    Blood in stools? ☐ Yes ☐ No
38. Hemorrhoids (piles)? ☐ Yes ☐ No
    Hernias (ruptures)? ☐ Yes ☐ No
39. Peptic ulcer disease? ☐ Yes ☐ No
40. Have you ever vomited blood? ☐ Yes ☐ No
41. Have you ever had a ☐ Sigmoidoscopy or ☐ Colonoscopy When? ______________________

Genitourinary

42. Cloudy urine? ☐ Yes ☐ No
43. Blood in urine? ☐ Yes ☐ No
44. Burn on urination? ☐ Yes ☐ No
45. History of kidney stones? ☐ Yes ☐ No
46. Do you get up at night several times to urinate? ☐ Yes ☐ No
47. For men, do you have difficulty initiating urination? ☐ Yes ☐ No