SURGICAL HISTORY QUESTIONNAIRE

Please complete this confidential form as carefully as you can. This will become a part of your medical record

Date _____ Full Name (First, Middle, Last) _____

Sex: ☐ Male ☐ Female Birthdate _____ Age _____

Primary Care Provider _____ Referring Physician _____

What is the main reason that you are visiting Bear Creek Medical Facility today and when did the problem start?

_____

_____

ALLERGIES

Allergies to Latex? ☐ Yes ☐ No
Allergies to medications? ☐ Yes ☐ No If yes please list:

Medication(s) your allergic to	Reaction(s)
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

Did you have any unusual childhood diseases such as rheumatic fever, heart disease, leukemia, kidney disease, hormone disorder, tumors?
Circle and explain _____

Do you bleed excessively or easily after accidents or medical procedures? ☐ Yes ☐ No
Have you ever required a transfusion? ☐ Yes ☐ No If yes, when and how many? _____

Please list the medical disease you are CURRENTLY being treated for or have been admitted to the hospital for treatment:

	Date of onset and/or duration
☐ High blood pressure	_____
☐ Diabetes	_____
☐ Heart attack(s)	_____
☐ Heart Failure	_____
☐ Stroke	_____
☐ Vascular (blood vessel) Disorders	_____
☐ Auto Immune Disorder	_____
☐ Cancer (current or past)	_____
☐ Hepatitis (what kind)	_____
☐ Covid (any variant)	_____
☐ Other:	_____

Have you had any of the following?

☐ Flu shot within the last year? When _____
☐ Pneumonia shot within last 10 years? When _____
☐ Covid Vaccine? (please circle): Pfizer Moderna J&J When _____
☐ Covid vaccine booster? (Please circle): Pfizer Moderna J&J When _____
☐ Diet or exercise recommendation to lower blood pressure? ☐ Diet or exercise recommendation to lower BMI?
☐ Tobacco cessation counseling? ☐ Colorectal cancer screening (Colonoscopy)

SURGICAL HISTORY QUESTIONNAIRE

FEMALES

How many pregnancies? _____ How many deliveries? _____ Age at birth of first child? _____

Cesarean sections? How many _____ Miscarriages or abortions? How many _____ Did you breast feed _____

Complications of pregnancy? _____

Age of first period _____ Date of last normal period _____ Date of last mammogram _____

FAMILY HISTORY

Please mark yes for living and no for deceased

	Yes	No	Age	Please list pertinent medical diseases
Mother	☐	☐	_____	_____
Father	☐	☐	_____	_____
Brother	☐	☐	_____	_____
Brother	☐	☐	_____	_____
Brother	☐	☐	_____	_____
Sister	☐	☐	_____	_____
Sister	☐	☐	_____	_____
Sister	☐	☐	_____	_____

SOCIAL HISTORY

Do you currently smoke/vape/chew tobacco? ☐ Yes ☐ No If yes, how much and how often? _____

Do you have a history of tobacco use? ☐ Yes ☐ No When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind and how often _____

Do you currently use any other drugs? ☐ Yes ☐ No What kind? _____

Are you currently ☐ Working ☐ Retired ☐ Student What kind of work? _____

Are you ☐ Single ☐ Married ☐ Partnered ☐ Widowed

SURGICAL HISTORY

Please list all surgeries **including colonoscopies, upper endoscopies**, etc. with dates and locations if possible

_____

_____

_____

_____

SURGICAL HISTORY QUESTIONNAIRE

MEDICATIONS and SUPPLEMENTS

(Please list doses and how often taken)

MISCELLANEOUS

(Please list any other pertinent information you feel will help us treat you)

SURGICAL HISTORY QUESTIONNAIRE

REVIEW OF SYSTEMS

(If yes to any of the following questions, please explain how recent and/or how often?)

CENTRAL NERVOUS SYSTEM

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

CARDIOVASCULAR (Please explain if you answer yes to any of these questions)

☐ Yes ☐ No Do you have chest pain, chest tightness or angina on exertion? _____
☐ Yes ☐ No At rest? _____
What is the duration of the chest pains? _____
☐ Yes ☐ No Chronic ankle swelling? _____
☐ Yes ☐ No Can you sleep flat in bed? _____
☐ Yes ☐ No Do you wake up at night short of breath? _____
☐ Yes ☐ No Do you have frequent dizzy or fainting spells? _____
☐ Yes ☐ No Do you have palpitations or an irregular heartbeat? _____
☐ Yes ☐ No Do you take antibiotics for dental procedures? _____

RESPIRATORY

☐ Yes ☐ No Do you get short of breath on mild exertion? _____
☐ Yes ☐ No Can you walk two flights of stairs without a significant discomfort? _____
☐ Yes ☐ No Do you have frequent yellow or green sputum? _____
☐ Yes ☐ No Has there been any changes in your voice recently? _____
☐ Yes ☐ No Do you have frequent or chronic chest pain? _____
☐ Yes ☐ No Do you cough up blood? _____
☐ Yes ☐ No Have you ever had phlebitis or blood clots in your legs? _____

GASTROINTESTINAL

☐ Yes ☐ No Have you lost or gained weight over the last several months? ☐ Yes ☐ No How much? _____
☐ Yes ☐ No Frequent nausea, vomiting, diarrhea or constipation? _____
☐ Yes ☐ No Change in bowel habits or stool size? _____
☐ Yes ☐ No Black tarry stool? _____
☐ Yes ☐ No Blood in stool? _____
☐ Yes ☐ No Hemorrhoids (piles)? _____
☐ Yes ☐ No Hernias? If yes, what kind? _____
☐ Yes ☐ No Peptic ulcer disease? _____
☐ Yes ☐ No Have you ever vomited blood? _____

Have you ever had a colonoscopy? ☐ Yes ☐ No Sigmoidoscopy? ☐ Yes ☐ No _____

GENITOURINARY

☐ Yes ☐ No Cloudy Urine? _____
☐ Yes ☐ No Blood in urine? _____
☐ Yes ☐ No Burn on urination? _____
☐ Yes ☐ No History of kidney stones? _____
☐ Yes ☐ No Do you get up at night several times to urinate? _____

For men: ☐ Yes ☐ No Do you have difficulty initiating urination? _____