

**General and Vascular Surgery**

**Patient History Questionnaire**

Please complete and bring this form with you to your first appointment.

Patient name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Referring physician: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Any/All other doctors you see: \_\_\_\_\_

Reason for your visit: \_\_\_\_\_

<b>For Office Use only-</b> Check the entry furthest to the right for HP1	Brief 1-3 elements	Brief 1-3 elements	Extended 4 + or 3 inactive	Extended 4 + or 3 inactive
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**HISTORY OF PRESENT ILLNESS (HP1)**

◇ Location: \_\_\_\_\_ *(Where on the body symptom occurs)*      ◇ Duration: \_\_\_\_\_ *(How long have you had symptom? How long does it last?)*

◇ Severity: \_\_\_\_\_ *(Severe, worse, slightly. Pain scale 1-10)*      ◇ Quality: \_\_\_\_\_ *(Character of symptom...burning, gnawing, stabbing)*

◇ Timing: \_\_\_\_\_ *(When symptoms occur)*      ◇ Context: \_\_\_\_\_ *(Situation associated with symptom)*

◇ Modifying Factors: \_\_\_\_\_ *(Things to make symptoms better or worse)*

◇ Associated Signs/Symptoms: \_\_\_\_\_ *(Other things that happen when this symptom occurs)*

<b>For Office Use only</b>				
Check entry furthest right for PFSH	None	None	1 or 2 HX areas	3 HX areas

**Past, Family History & Social History**

**Medical History:** Please circle **Yes** or **No** if you have any of the following medical problems.

High Blood Pressure . . Yes    No      Diabetes . . Yes    No      Heart Trouble . Yes    No  
 Respiratory Problems . . Yes    No      Stroke . . . . Yes    No      Cancer . . . . . Yes    No  
 Bleeding Problems . . . . Yes    No      Other Problems \_\_\_\_\_

**What is your current weight?** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

**Past Hospitalizations/Surgeries/Injuries and Approximate Dates:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History:** *Please list any medical problems in your relatives.*

Father: \_\_\_\_\_ Mother: \_\_\_\_\_ Siblings: \_\_\_\_\_

Others: \_\_\_\_\_

**Social History:** Marital Status:  Single  Married  Separated  Divorced  Widowed  
 Tobacco Use:  Never  Quit/ When? \_\_\_\_\_  Smoker/ how much? \_\_\_\_\_  
 Alcohol Use:  Never  Rarely  Moderate  Daily  How much? \_\_\_\_\_  
 Drug Use:  Never  Type and frequency \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Other: \_\_\_\_\_

<b>For Office Use only</b>				
Check entry furthest right for ROS	None	Pertinent- 1 System	Extended- 2-9 Systems	Complete-10 systems or some systems with all others negative

**Review of Systems** *Please circle Yes or No if you have any of the following problems.*

<p>◇ <b>Constitutional</b></p> <p>Good General Health    Yes   No</p> <p>Recent weight change    Yes   No</p> <p>Night sweats, fevers    Yes   No</p> <p>Fatigue    Yes   No</p> <p>◇ <b>Cardiovascular</b></p> <p>Chest pain    Yes   No</p> <p>Palpitations    Yes   No</p> <p>Heart trouble    Yes   No</p> <p>Swelling hands/feet    Yes   No</p> <p>◇ <b>Musculoskeletal</b></p> <p>Muscle pain or cramp    Yes   No</p> <p>Stiffness/swelling joints    Yes   No</p> <p>Joint pain    Yes   No</p> <p>Trouble walking    Yes   No</p> <p>◇ <b>Endocrine</b></p> <p>Excessive thirst/urination    Yes   No</p> <p>Thyroid disease    Yes   No</p> <p>Hormone problem    Yes   No</p> <p>◇ <b>Genitourinary -Male only</b></p> <p>Blood in urine    Yes   No</p> <p>Kidney stones    Yes   No</p> <p>Sexual problems    Yes   No</p> <p>Testicle pain    Yes   No</p>	<p>◇ <b>Ears/Nose/Mouth/Throat</b></p> <p>Hearing loss or ringing    Yes   No</p> <p>Sinus problems    Yes   No</p> <p>Nose bleeds    Yes   No</p> <p>Sore throat/voice change    Yes   No</p> <p>◇ <b>Respiratory</b></p> <p>Shortness of breath    Yes   No</p> <p>Cough    Yes   No</p> <p>Wheezing/asthma    Yes   No</p> <p>Coughing up blood    Yes   No</p> <p>◇ <b>Neurological</b></p> <p>Frequent headaches    Yes   No</p> <p>Paralysis or tremors    Yes   No</p> <p>Convulsions/seizures    Yes   No</p> <p>Numbness/tingling    Yes   No</p> <p>◇ <b>Hematologic / Lymphatic</b></p> <p>Bruise easily    Yes   No</p> <p>Slow to heal    Yes   No</p> <p>Enlarged glands    Yes   No</p> <p>◇ <b>Genitourinary -Female only</b></p> <p>Blood in urine    Yes   No</p> <p>Kidney stones    Yes   No</p> <p>Sexual problems    Yes   No</p> <p>Menstrual problems    Yes   No</p>	<p>◇ <b>Eyes</b></p> <p>Wear glasses/contacts    Yes   No</p> <p>Blurred/double vision    Yes   No</p> <p>Eye disease or injury    Yes   No</p> <p>Glaucoma    Yes   No</p> <p>◇ <b>Gastrointestinal</b></p> <p>Nausea/vomiting    Yes   No</p> <p>Abdominal pain    Yes   No</p> <p>Rectal bleeding    Yes   No</p> <p>Bowel problems    Yes   No</p> <p>◇ <b>Integumentary (Skin/Breast)</b></p> <p>Change in hair or nails    Yes   No</p> <p>Rashes or itching    Yes   No</p> <p>Breast lump    Yes   No</p> <p>Breast pain/discharge    Yes   No</p> <p>◇ <b>Allergic/Immunologic</b></p> <p>Food allergies    Yes   No</p> <p>Aspirin allergies    Yes   No</p> <p>Antibiotic allergies    Yes   No</p> <p>◇ <b>Psychiatric</b></p> <p>Insomnia    Yes   No</p> <p>Confusion/memory loss    Yes   No</p> <p>Depression    Yes   No</p>
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<b>Patient statement:</b>	To the best of my knowledge, the above information is accurate and complete.
	Signed _____ Date _____
<b>Physician Statement:</b>	I have reviewed the questionnaire with the patient.
	Signed _____ Date _____