

Please Fill out Health History as completely as possible. Front and Back .....please

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Health History**

**Medications/Allergies**

Date of last physical examination? \_\_\_\_\_

List medications you are taking \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

Is this visit a result of an accident? \_\_\_\_\_

Date of accident \_\_\_\_\_

Where is the location of your problem? \_\_\_\_\_

List any allergies you have to drugs/medication \_\_\_\_\_

Are there activities that make your problem worse? \_\_\_\_\_

Date of onset, signs and symptoms of your problem? \_\_\_\_\_

Please list all surgeries you have had and when \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how much \_\_\_\_\_

Do you drink alcohol? If yes, how much \_\_\_\_\_

Have you had a colonoscopy in the past? \_\_\_\_\_ When? \_\_\_\_\_

Is there any family history of colon cancer? \_\_\_\_\_

Please (x) conditions you have today or have had in the past:

**Skin**

- \_\_\_ AIDS
- \_\_\_ Anemia
- \_\_\_ Appendicitis
- \_\_\_ Arthritis
- \_\_\_ Bleeding disorder
- \_\_\_ Breast Lump
- \_\_\_ Cancer
- \_\_\_ Cough-Productive
- \_\_\_ Diabetes
- \_\_\_ Difficulty breathing
- \_\_\_ Emphysema/COPD
- \_\_\_ Heart disease
- \_\_\_ Hepatitis
- \_\_\_ Kidney disease

- \_\_\_ Liver Disease
- \_\_\_ Lymphoma
- \_\_\_ Stroke
- \_\_\_ Sickle cell Disease
- \_\_\_ Thyroid Problems
- \_\_\_ Tuberculosis
- \_\_\_ Ulcers

- \_\_\_ Rash
- \_\_\_ New growth/lumps
- \_\_\_ Change in mole
- \_\_\_ Sore that won't heal
- \_\_\_ Bruise easily

**Family History**

	Father	Present health or cause of death	Mother	Present health or cause of death	Spouse	Present health or cause of death
Alive		_____		_____		_____
Deceased		_____		_____		_____
Brothers	# Alive	Health	# Deceased	Cause of Death		
Sisters	# Alive	Health	# Deceased	Cause of Death		
Children	# Alive	Health	# Deceased	Cause of Death		
CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES						
	Diabetes	Cancer	Bleeding Tendency	Kidney Disease	Tuberculosis	
	Heart Disease	Stroke	High Blood Pressure	Nervous Illness	Allergy	Other

**Check ( x ) symptoms you currently have or have had in the past year**

**General**

- Chills
- Depression/nervousness
- Dizziness/Fainting
- Fever
- Loss of weight
- Numbness
- Loss of sleep
- Recent Chemotherapy
- Recent Radiation

**Gastrointestinal**

- Heartburn/indigestion
- Vomiting
- Constipation
- Diarrhea
- Black stools
- Blood in stools

**Muscle/Joint/Bone**

Pain, Weakness, numbness in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

**Cardiovascular**

- Chest Pain
- High/Low Blood Pressure
- Swelling of ankles/legs
- Varicose Veins
- Poor Circulation
- Leg pain at rest
- Leg pain walking

**Woman Only**

Are you pregnant? Yes   
No

Due Date \_\_\_\_\_

\_\_\_\_ Breast Lump and date you

First noticed it \_\_\_\_\_

Have you had a  
Mammogram \_\_\_\_\_

When? \_\_\_\_\_

Were there any  
abnormalities \_\_\_\_\_

**Genitourinary**

- Blood in urine
- Urinary tract infection
- Painful urination
- Kidney Stones
- Prostate or testicular problems

**Eyes, Ears, Nose, Mouth, Throat**

- Blurred/double vision
- Glasses/contacts
- Ringing in ears
- Change in hearing
- Sore throat

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

**Signatures**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. As a patient of the Ozark Surgical Associates, I do hereby voluntarily consent to such medical care and treatment encompassing standard diagnostic procedures, and the performance of any other procedures by the Ozark Surgical Associates as their judgment deems medically advisable.

I understand that if I have any questions regarding my examination, I may request an explanation at any time.  
(Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.)

\_\_\_\_\_  
Signature of Patient, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name of the Above Signature

\_\_\_\_\_  
Relationship to Patient