

Please Fill out Health History as completely as possible. Front and Backplease

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

Skin

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

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

- Abnormal Pap Smear
- Date of Last Menstrual period _____
- Are They regular _____
- Breast lump and date you

First noticed it _____

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
- Trouble swallowing

Have you had a Mammogram _____

when? _____

Were there any abnormalities?

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