

# Patient History – General Surgeons of Western Colorado

1001 Wellington Avenue Grand Junction, CO 81501 970 243 0900

Patient's Name \_\_\_\_\_  
Age \_\_\_\_\_ Height \_\_\_\_\_

Date \_\_\_\_\_  
Weight \_\_\_\_\_

## Past Medical History (place an X in the box next to your associated medical conditions)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Crohn's disease           |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Hyperthyroid (high level) |
| <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Irritable bowel       | <input type="checkbox"/> Hypothyroid (low level)   |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Stomach ulcer         | <input type="checkbox"/> Breast cancer             |
| <input type="checkbox"/> Migraines      | <input type="checkbox"/> Kidney stones         | <input type="checkbox"/> Colon cancer              |
| <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Enlarged prostate     | <input type="checkbox"/> Uterine cancer            |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Skin cancer               |
| <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Heart valve damage    | <input type="checkbox"/> Prostate cancer           |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Heart murmur          | <input type="checkbox"/> Lung cancer               |
| <input type="checkbox"/> Gallstones     | <input type="checkbox"/> Ulcerative colitis    | <input type="checkbox"/> Mouth cancer              |
| <input type="checkbox"/> Heart attack   | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Thyroid cancer            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Pancreatitis          | <input type="checkbox"/> Other cancer              |
| <input type="checkbox"/> HIV positive   | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Kidney failure            |
| <input type="checkbox"/> Hernia         | <input type="checkbox"/> Breast Mass           | <input type="checkbox"/> Hemorrhoids               |

Other \_\_\_\_\_

## Previous Operations (Next to your previous operation, write in your **age** at the time surgery was done)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> _____ Hernia                     | <input type="checkbox"/> _____ Colonoscopy            | <input type="checkbox"/> _____ Colon surgery   |
| <input type="checkbox"/> _____ Mastectomy                 | <input type="checkbox"/> _____ Breast biopsy          | <input type="checkbox"/> _____ Gallbladder     |
| <input type="checkbox"/> _____ Appendix                   | <input type="checkbox"/> _____ Hemorrhoid surgery     | <input type="checkbox"/> _____ Stomach ulcer   |
| <input type="checkbox"/> _____ Prostate surgery           | <input type="checkbox"/> _____ Carotid artery surgery | <input type="checkbox"/> _____ Tonsils         |
| <input type="checkbox"/> _____ Coronary artery bypass     | <input type="checkbox"/> _____ Varicose veins         | <input type="checkbox"/> _____ Angioplasty     |
| <input type="checkbox"/> _____ Plates/screws for fracture | <input type="checkbox"/> _____ Organ transplant       | <input type="checkbox"/> _____ Heart valve     |
| <input type="checkbox"/> _____ Pacemaker                  | <input type="checkbox"/> _____ Hip surgery            | <input type="checkbox"/> _____ Breast implants |
| <input type="checkbox"/> _____ C-section                  | <input type="checkbox"/> _____ Plastic surgery        | <input type="checkbox"/> _____ Hysterectomy    |
| <input type="checkbox"/> _____ Leg bypass surgery         | <input type="checkbox"/> _____ Aortic aneurysm repair | (and ovaries Yes No)                           |

Complications or other surgeries \_\_\_\_\_

## Social History

Do you smoke? Yes No \_\_\_\_\_  
How many years? \_\_\_\_\_  
How many packs per day? \_\_\_\_\_  
Do you drink alcohol? Yes No \_\_\_\_\_  
How much/often? \_\_\_\_\_  
Do you use recreational drugs? Yes No \_\_\_\_\_  
What is your occupation \_\_\_\_\_

## Gynecologic History

Date of your last period \_\_\_\_\_ Have you had tubal ligation (sterilization)? \_\_\_\_\_  
Age at your first period \_\_\_\_\_ Age at your first pregnancy \_\_\_\_\_  
How many pregnancies have you had? \_\_\_\_\_ How many children have you had? \_\_\_\_\_  
Age at menopause \_\_\_\_\_

## Family History

(Please identify which family member had the following conditions – **M**other, **F**ather, **S**ister, **B**rother, **C**hildren)

Colon cancer	M F S B C	Heart disease	M F S B C	Ovarian cancer	M F S B C
Colon polyps	M F S B C	Stroke	M F S B C	Pancreas cancer	M F S B C
Uterine cancer	M F S B C	Diabetes	M F S B C	Other cancers	M F S B C
Skin cancer	M F S B C	Bleeding disorder	M F S B C	Inheritable diseases	M F S B C
Breast cancer	M F S B C	Ulcerative colitis	M F S B C	Sickle cell anemia	M F S B C
Lung cancer	M F S B C	Crohn's disease	M F S B C	Anesthesia problems	M F S B C

Other diseases that run in your family \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

**Medications** (please include all prescription, over-the-counter, herbals or dietary supplements)

Do you take aspirin, Coumadin or other blood thinners daily? Yes \_\_\_ No \_\_\_

Medicine	Dose (how much?)	How often?

**Allergies to Medications** (please list the medication and your reaction to this medication)

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**Constitutional:**

Do you have fever? Yes No  
 Do you have recent weight loss? Yes No  
 Do you have nausea? Yes No  
 Do you have chills? Yes No

**Anesthesia:**

Prior problems with anesthesia? Yes No  
 Trouble waking up at surgery? Yes No  
 Nausea and vomiting with surgery? Yes No  
 Family with malignant hyperthermia? Yes No

**Eyes:**

Have your eyes turned yellow? Yes No  
 Do you have double vision? Yes No

**Head, Ears, Nose, and Neck:**

Any cancer of the head and neck? Yes No  
 Do you have loose teeth? Yes No  
 Any chronic sinus problems? Yes No  
 Any frequent nose bleeds? Yes No  
 Any lumps and bumps in the neck? Yes No  
 Do you have sleep apnea? Yes No

**Cardiac:**

Do you have chest pain? Yes No  
 Have you had a heart attack? Yes No  
 Have you had angioplasty? Yes No  
 Do you have heart failure? Yes No

**Lungs:**

Have you had lung blood clots? Yes No  
 Do you have chronic bronchitis? Yes No  
 Any severe shortness of breath? Yes No  
 Chronic cough? Yes No

**Vascular:**

Any problems with blood vessels? Yes No  
 Any known narrowing of vessels? Yes No

**Gastrointestinal:**

Do you have diarrhea? Yes No  
 Do you have constipation? Yes No  
 Do you have blood in the stool? Yes No  
 Do you have black stool? Yes No  
 Do you have mucus in the stool? Yes No  
 Do you have narrowing of the stool? Yes No  
 Have you had bleeding ulcers? Yes No  
 Do you have abdominal pain? Yes No  
 Have you had jaundice? Yes No  
 Do you have cirrhosis? Yes No

**Genitourinary:**

Do you get urinary infections? Yes No  
 Do you have blood in the urine? Yes No  
 Any pain/burning when you urinate? Yes No

**Neurologic:**

Have you had seizures or epilepsy? Yes No  
 Have you had a stroke or TIA? Yes No  
 Do you have multiple sclerosis? Yes No  
 Have you had a major head injury? Yes No

**Psychiatric:**

Do you have a psychiatric disorder? Yes No  
 Are you bipolar? Yes No

**Endocrine:**

Do you have Thyroid problems? Yes No  
 Do you have Parathyroid problems? Yes No

**Musculoskeletal:**

Do you have pain in your joints? Yes No  
 Do you have Gout? Yes No  
 Do you have Spinal disc problem? Yes No

**Hematologic:**

Do you have bleeding problems? Yes No  
 Prior blood clots in legs? Yes No  
 Do you have sickle cell disease? Yes No

