West Michigan Surgical Specialists **PATIENT HISTORY FORM** DATE: _____

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

SOCIAL HISTORY: □ Single □ Married □ Divorced □ Widowed Advanced Directive: □ YES □ NO
Occupation: _____ □ Retired _____ □ Disabled

ALLERGIES: To Medications □ NONE Type Reaction

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES:
Latex □ YES □ NO
Dye □ YES □ NO
Tape □ YES □ NO
Iodine /Shellfish □ YES □ NO

Smoker: □ YES □ NO Quit: _____ Packs per day: _____ Number of years smoked: _____
Alcohol: □ YES □ NO Number of drinks per day : _____ Drug Use or Addiction □ YES □ NO

PREVIOUS SURGERIES / HOSPITALIZATIONS and Approximate dates □ IF NONE

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

IMPLANTS / DEVICES: List site of implant, ie.-left hip _____
ANESTHESIA –related problems: □ NONE If YES- explain _____
Malignant Hyperthermia □ YES □ NO Family History of Anesthesia Problems □ YES □ NO

Personal Cancer History □ NONE □ YES Type _____ Leukemia □ YES □ NO
Other Serious Disease □ NONE □ YES _____
Have you had a COLONOSCOPY □ YES □ NO EGD □ YES □ NO COLON POLYP REMOVED □ YES □ NO

FAMILY CANCER HISTORY

Mother □ NO □ YES Type _____ Age Diagnosed ____ Current Age ____ Age at Death ____
Father □ NO □ YES Type _____ Age Diagnosed ____ Current Age ____ Age at Death ____
Brother □ NO □ YES TYPE _____ Age Diagnosed ____ Current Age ____ Age at Death ____
Sister □ NO □ YES TYPE _____ Age Diagnosed ____ Current Age ____ Age at Death ____

Have you been seen in an Emergency Department or been hospitalized in the past 12 months □ NO
□ YES WHEN _____ WHERE _____ REASON _____
WHEN _____ WHERE _____ REASON _____

In the past 3 years have you seen a:
PULMONOLOGIST (lung) □ NO □ YES DR. _____ WHEN _____ NEXT APPOINTMENT _____
CARDIOLOGIST(heart) □ NO □ YES DR. _____ WHEN _____ NEXT APPOINTMENT _____
VASCULAR SURGEON □ NO □ YES DR. _____ WHEN _____ NEXT APPOINTMENT _____

In the past 3 years have you had:

□ NO	□ YES	EKG or ECG	Where: _____
□ NO	□ YES	ECHO	Where: _____
□ NO	□ YES	Heart Cath	Where: _____
□ NO	□ YES	Stress Test	Where: _____
□ NO	□ YES	Holter Monitor	Where: _____
□ NO	□ YES	Pacemaker	Where: _____
□ NO	□ YES	Defibrillator	Where: _____
□ NO	□ YES	Carotid Artery Testing	Where: _____
□ NO	□ YES	Pulmonary Function	Where: _____

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Name: _____ Date of Birth: _____

HEIGHT: _____ WEIGHT: _____ BMI: _____

CONSTITUTIONAL

☐ No	☐ Yes	Unexpected Change in Weight _____lbs
☐ No	☐ Yes	Weakness
☐ No	☐ Yes	Fatigue
☐ No	☐ Yes	Unexplained Fevers, Sweats, or Chills
☐ No	☐ Yes	Difficulty Sleeping

CARDIOVASCULAR

☐ No	☐ Yes	High Blood Pressure
☐ No	☐ Yes	Heart Problems
☐ No	☐ Yes	Heart Attack
☐ No	☐ Yes	Chest Pain
☐ No	☐ Yes	Shortness of Breath
☐ No	☐ Yes	Leg Swelling
☐ No	☐ Yes	Irregular Heart Rhythm
☐ No	☐ Yes	Passing Out

RESPIRATORY

☐ No	☐ Yes	Sleep Apnea
☐ No	☐ Yes	Use CPAP
☐ No	☐ Yes	Sleep Study-where _____
☐ No	☐ Yes	Asthma
☐ No	☐ Yes	COPD / Emphysema
☐ No	☐ Yes	TB
☐ No	☐ Yes	Use Oxygen

GENITOURINARY

☐ No	☐ Yes	Kidney Disease
☐ No	☐ Yes	Urinary Frequency
☐ No	☐ Yes	Urinary Tract Infections
☐ No	☐ Yes	Kidney Stones
☐ No	☐ Yes	Blood in Urine
☐ No	☐ Yes	Prostate Problems

ENDOCRINE

☐ No	☐ Yes	Diabetes Mellitus
☐ No	☐ Yes	Thyroid Problems
☐ No	☐ Yes	Parathyroid Problems

SKIN

☐ No	☐ Yes	Unusual Itching
☐ No	☐ Yes	Rash
☐ No	☐ Yes	New Skin Lesion
☐ No	☐ Yes	Color Changes
☐ No	☐ Yes	New Sores

Patient Signature: _____

Date: _____

GASTROINTESTINAL

☐ No	☐ Yes	Pancreatitis
☐ No	☐ Yes	Colitis
☐ No	☐ Yes	Diverticulitis
☐ No	☐ Yes	Abdominal Pain
☐ No	☐ Yes	Change in Bowel Habits
☐ No	☐ Yes	Nausea
☐ No	☐ Yes	Vomiting
☐ No	☐ Yes	Diarrhea
☐ No	☐ Yes	Constipation
☐ No	☐ Yes	Black or Bloody Stool
☐ No	☐ Yes	Heartburn / Reflux / GERD
☐ No	☐ Yes	Liver Disease
☐ No	☐ Yes	Hepatitis
☐ No	☐ Yes	Stomach Ulcers
☐ No	☐ Yes	Last Colonscopy _____

BREAST-MALE & FEMALE

☐ No	☐ Yes	New Breast Lump / Mass
☐ No	☐ Yes	Breast Pain
☐ No	☐ Yes	Nipple Discharge
☐ No	☐ Yes	Unusual Itching
☐ No	☐ Yes	Rash
☐ No	☐ Yes	New Skin Lesion
☐ No	☐ Yes	Color Changes
☐ No	☐ Yes	New Sores

HEMATOLOGICAL (BLOOD)

☐ No	☐ Yes	Abnormal Bleeding
☐ No	☐ Yes	Bruising
☐ No	☐ Yes	Anemia
☐ No	☐ Yes	Blood clots (PE or DVT)
☐ No	☐ Yes	Received blood transfusion

PSYCHIATRIC

☐ No	☐ Yes	Depression
☐ No	☐ Yes	Anxiety
☐ No	☐ Yes	Other: _____

NEUROLOGICAL

☐ No	☐ Yes	Seizures
☐ No	☐ Yes	Stroke
☐ No	☐ Yes	Chronic Headaches
☐ No	☐ Yes	Memory Loss

Revwd: _____ Date: _____

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Revwd: _____ Date: _____

Revwd: _____ Date: _____