Talbert General Surgery Patient History

Date: _____ Chief Complaint: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Primary /Referring Physician: _____

Pharmacy: _____

MEDICAL HISTORY: CIRCLE any below that you have been diagnosed with or currently being treated for:

☐ Bleeding tendency	☐ Heart disease	☐ Kidney trouble	☐ Thyroid disease
☐ Bronchitis/emphysema	☐ High blood pressure	☐ Diabetes	☐ Heart valve problem
☐ Liver disease	☐ Kidney stones	☐ Gout	☐ Blood clots legs or DVT
☐ Tuberculosis	☐ Sleep apnea	☐ Stroke	☐ Blood clots Lungs or PE
☐ Cancer, Type: _____		☐ Heart attack, when: _____	

Do you have any objections to receiving blood? ☐ Yes ☐ No

SURGICAL HISTORY:

	Operation	*Year*	*Surgeon*
1.			
2.			
3.			
4.			
5.			
6.			

Last Colonoscopy: _____

ALLERGIES:

	Medication	*Adverse Reaction*
1.		
2.		
3.		
4.		
5.		

Reaction to anesthesia? ☐ Yes or ☐ No If yes: _____
IVP Dye / Contrast? ☐ Yes or ☐ No If yes: _____
Iodine / Shellfish? ☐ Yes or ☐ No If yes: _____

MEDICATIONS: List the name and dosage of all medicines you are taking

_____ _____
_____ _____
_____ _____

Hormone/Birth Control: _____
Herbal / Dietary Supplements: _____

FAMILY HISTORY: CIRCLE if present in any of your immediate family
☐ Heart Disease ☐ Kidney Disease ☐ Tuberculosis ☐ Diabetes ☐ Bleeding Disorders
Cancer; if yes Relative _____ Type _____ Age: _____

****PLEASE TURN PAGE OVER TO COMPLETE THE FORM****

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PERSONAL / SOCIAL HISTORY:

Alcohol Use: How many alcoholic drinks do you consume per day_____ per week_____

Current / Former Occupation: _____

Do you require antibiotics before dental / surgical procedures? ☐Yes or ☐No

Do you use illegal substances? ☐Yes or ☐No If yes, what:_____

Tobacco Use: ☐ Yes or ☐ No

Currently smoke _____ packs per day for _____ years Quit in _____(year)

REVIEW OF SYMPTOMS: Do you have any of the following symptoms or conditions?

Constitutional Symptoms	Yes	No		**Breasts**	Yes	No
Fever	☐	☐		Skin rash	☐	☐
Chills	☐	☐		Breast lump	☐	☐
Headache	☐	☐		Persistent itch	☐	☐
Other:_____				Other:_____		
Eyes				**Ear/Nose/Throat/Mouth**		
Blurred vision	☐	☐		Ear infection	☐	☐
Double vision	☐	☐		Sore throat	☐	☐
Pain	☐	☐		Sinus problems	☐	☐
Other:_____				Other:_____		
Cardiovascular				**Respiratory**		
Chest pain	☐	☐		Infections	☐	☐
Varicose veins	☐	☐		Frequent cough	☐	☐
High blood pressure	☐	☐		Shortness of breath	☐	☐
Other:_____				Other:_____		
Gastrointestinal				**Genitourinary**		
Abdominal pain	☐	☐		Urine retention	☐	☐
Nausea/Vomiting	☐	☐		Painful urination	☐	☐
Gastrointestinal bleeding	☐	☐		Urinary frequency	☐	☐
Other: _____				Other:_____		
Musculoskeletal				**Psychologic**		
Back Pain	☐	☐		Depression	☐	☐
Neck Pain	☐	☐		Anxiety	☐	☐
Other:_____				Other:_____		
Endocrine				**Hematological/Lymphatic**		
Thyroid symptoms	☐	☐		Enlarged lymph nodes	☐	☐
Other:_____				Other:_____		

The Federal Government now requires that I counsel ALL patients not to smoke, even if they never smoked. Please be aware that, as your surgeon, I strongly encourage all my patients to quit smoking immediately, and I strongly encourage my nonsmokers to never start smoking.

Patient Signature: _____ Date: _____

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OFFICE USE ONLY

Physician Signature: _____ Date: _____

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VITAL SIGNS: HT_____ WT _____ BP _____ PULSE _____ RESP_____ TEMP_____