UnityPoint Clinic

General Surgery-Des Moines

Health History Questionnaire

Name_____ Date_____

Date of Birth_____ Referring Doctor_____

Reason for seeing the Doctor: _____

_____

When did it start?_____

What makes it better?_____

What makes it worse? _____

_____

Medical History (Please circle one)

Do you have Diabetes	Yes	No	
Do you have High Blood Pressure	Yes	No	
Do you have Heart Disease	Yes	No	
Do you have Lung Disease	Yes	No	
Have you had a Mammogram	Yes	No	When _____
Have you had a Colonoscopy	Yes	No	When _____

If yes, please explain_____

_____

_____

Have you been hospitalized in the last 6 months? Yes No

If yes, please explain_____

_____

_____

Allergies: _____

Please list all your current medications:

Name	Dose	Frequency
-		

Surgical History

Please list any surgeries performed:

Surgery	Year

Social History

Do you smoke? Yes No

If yes, number of packs per day_____ what age did you start_____

Do you consume alcohol? **(Circle One)** Never Rarely Moderately Daily

What is your Occupation? _____

Family History

If living, age and any medical illnesses If deceased, age and cause of death

Mother_____

Father_____

Siblings_____

Have any relatives ever had: (Circle the ones that apply)

Alcoholism Bleeding tendency Cancer Diabetes Heart Disease

Stroke Seizures Ulcer Disease Liver Disease High Blood Pressure

Review of Systems

If you have any of the following, please circle YES

General

Recent weight change	Yes	No
If yes, how much _____		

Skin

Itching	Yes	No
Jaundice	Yes	No
Hives	Yes	No
Infection or boils	Yes	No
Abnormal Pigmentations	Yes	No

Head, Eyes, Ears, Nose, Throat

Eye Disease or Injury	Yes	No
Headaches	Yes	No
Glaucoma	Yes	No
Double Vision	Yes	No
Frequent Nosebleeds	Yes	No
Sinus Infections	Yes	No
Ear Disease	Yes	No
Impaired Hearing	Yes	No
Dizziness	Yes	No

Neck

Stiffness	Yes	No
Enlarged Glands	Yes	No

Respiratory

Frequent Colds	Yes	No
Coughing up Blood	Yes	No
Asthma or Wheezing	Yes	No
Difficulty Breathing	Yes	No
Lung Disease	Yes	No
Pleurisy or Pneumonia	Yes	No

Cardiovascular

Chest pain or Angina	Yes	No
Shortness of Breath	Yes	No
Difficulty walking 2 blocks or more	Yes	No
Heart Disease	Yes	No
High/Low Blood Pressure	Yes	No
Swelling of the ankles	Yes	No
Heart Murmur	Yes	No
Racing Heart Beat	Yes	No
Stroke	Yes	No

Hematologic

Slow to Heal	Yes	No
Blood Diseases	Yes	No
Anemia	Yes	No
Blood Clots	Yes	No
Bruise Easily	Yes	No

Genitourinary

Loss of Urine	Yes	No
Night Time Urination	Yes	No
Frequent Urination	Yes	No
Straining to Urinate	Yes	No
Pain or Burning With Urination	Yes	No
Blood in Urine	Yes	No

Gynecological (if applicable)

Are you Pregnant	Yes	No
Number of Pregnancies_____		
Number of Children_____		
Last Menstrual period_____		
Frequent Periods	Yes	No

Neuro-Psychiatric

Are you receiving any Psychiatric Therapy	Yes	No
Fainting Spells	Yes	No
Convulsions	Yes	No
Sleep Difficulties	Yes	No
Depression	Yes	No
Do you cry often	Yes	No
Have you ever considered suicide	Yes	No
Used any hard drugs	Yes	No

Endocrine

Thyroid Disease	Yes	No
Dry Skin	Yes	No
High or Low Blood Sugar	Yes	No
Do you take Insulin	Yes	No
Tire Easily	Yes	No

Gastrointestinal and Liver History

Have you ever had any of the following, please circle ANY that apply

Jaundice Liver Trouble Hepatitis Liver Cirrhosis Parasites

Infectious Dysentery Colitis Diverticulitis Gallbladder Disease

Gallstones Enlarged Spleen Injury to your intestinal or stomach organs

Does food stick when you swallow	Yes	No
Do you ever have pain when swallowing	Yes	No
If so, for how long_____		
How often does this happen	Yes	No
Does this happen only with solid foods	Yes	No
Does this happen only with Liquids	Yes	No
Are you troubled by heartburn	Yes	No
Do you frequently vomit	Yes	No
Have you vomited blood	Yes	No
Have you had a change in your bowel habits	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Have you had any bloody stools	Yes	No
Have you had any black stools	Yes	No
Do you have relatives that have colon polyps	Yes	No
Do you have relatives that have colon or rectal cancer	Yes	No
Do you have any relatives With Crohns Disease or Ulcerative Colitis	Yes	No
Have you ever had any blood transfusions	Yes	No
Have you ever had Hepatitis	Yes	No
Do you have any tattoos	Yes	No
Are you worried that you could have AIDS	Yes	No

Is there any other information you feel may be helpful to the Doctor?

_____

_____

_____

_____

_____

Physician Signature_____