Surgical Associates of Marshall County
Health History Form

Date: ______________ Name: ____

Date of Birth: _____________ Height: _____________ Weight:_____________ BMI: _____________

Medications you are currently taking: (Please include dosage and frequency)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Are you currently taking any of the following blood thinners?

☐ Aspirin ☐ Plavix ☐ Coumadin

Allergies to Medications: ☐ No known drug allergies ☐ Latex Allergy

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Past Hospitalizations and Surgeries: (Please list date, hospital, and procedure)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Do you have any of the following?

☐ High blood pressure ☐ Diabetes ☐ Heart Disease

☐ Reflux (heartburn) ☐ Sleep Apnea ☐ with C-PAP

Medical History and Review of Systems

Do you have, or have you ever had: (Please check all that apply)

Cardiac: ☐ Shortness of Breath ☐ Heart cath/stents ☐ Abnormal Stress Test/EKG ☐ Atrial fibrillation

General: ☐ Cancer ☐ HIV ☐ Headaches ☐ Weight loss ☐ Weight gain ☐ Snoring

GI: ☐ Nausea/vomiting ☐ Throwing up blood ☐ Difficulty swallowing ☐ Constipation ☐ Diarrhea ☐ Abnormal bowel movements ☐ Blood in bowel movements ☐ Colored bowel movements

Pulmonary: ☐ Coughing up blood ☐ Wheezing ☐ Cough

Skin: ☐ Black spot ☐ Skin lesion that has changed shape/size/color ☐ Skin lesion that bleeds

Vascular: ☐ Ulcer on legs ☐ Varicose veins ☐ Spider veins

Social History: ☐ Alcohol ☐ Illicit Drugs ☐ Tobacco

Immediate Family's Health History: (State of health/medical conditions or cause of death)

Father: ____

Mother: ____

Siblings: ____

Children: ____

WOMEN ONLY:
Approximate date of last menstrual period: ________________ Last mammogram: ________________

Additional patient comments: ____

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By signing below, I am stating that I have filled out the above health and medical history to the best of my knowledge. Any item left blank is to be considered answered in the negative (no or none).

X ____
Signature