GHADIALI
General Surgery
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***Laparoscopic Surgery • Surgical Oncology***
***Gastrointestinal Surgery • Thyroid Surgery***
***Hernia Surgery • Endoscopy***

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# Health History

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient's Name: _____ Birthdate: _____ Date: _____

Chief Complaint: _____

**History of Present Illness:**

Location: _____ Quality: _____
(Where is the pain/problem?) (Example: normal vs. abnormal color, activity, etc.)

Severity: _____ Duration: _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe) (How long have you had this pain/problem? Or, when did it start?)

Timing: _____ Context: _____
(Does this pain/problem occur at a specific time?) (Where were you at the onset of the pain/problem?)

Associated Symptoms: _____ Modifying Factors: _____
(What other associated problems have you been having?) (What makes the pain/problem worse or better? Or, have you had previous episodes?

**Past Medical History:**

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Measles | no | yes | Anemia | no | yes | Back Trouble | no | yes | Hepatitis | no | yes |
| Mumps | no | yes | Bladder Infection | no | yes | High Blood Pressure | no | yes | Ulcer | no | yes |
| Chickenpox | no | yes | Epilepsy | no | yes | Low Blood Pressure | no | yes | Kidney Disease | no | yes |
| Whooping cough | no | yes | Migraine Headache | no | yes | Hemorrhoids | no | yes | Thyroid Disease | no | yes |
| Scarlet Fever | no | yes | Tuberculosis | no | yes | Date of Last Chest X-Ray | | | Bleeding Tendency | no | yes |
| Diptheria | no | yes | Diabetes | no | yes | Asthma | no | yes | Any Other Disease | no | yes |
| Small Pox | no | yes | Cancer | no | yes | Hives or Eczema | no | yes | (Please List) | | |
| Pneumonia | no | yes | Polio | no | yes | AIDS or HIV 1 | no | yes | | | |
| Rheumatic Fever | no | yes | Glaucoma | no | yes | Infectious Mono | no | yes | | | |
| Heart Disease | no | yes | Hernia | no | yes | Bronchitis | no | yes | | | |
| Arthritis | no | yes | Blood or Plasma | | | Mitral Valve Prolapse | no | yes | | | |
| Venereal Disease | no | yes | Transfusion | no | yes | Stroke | no | yes | | | |

**Previous Hospitalizations/Surgeries/Serious Illness:**

_____

_____

**Allergies:** _____

**Medications: (Include nonprescription)**

_____

_____

**Patient Social History:**

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco: Never: _____ Previously, but quit: _____ Current, # packs/day: _____
Use of Drugs: Never: _____ Type/Frequency: _____

**Family Medical History:** Age: Disease: If Deceased, Cause of Death:

Father: _____
Mother: _____
Sibling: _____
_____
Spouse: _____
Children: _____
_____

**Review of Symptoms:** Please indicate any personal history below:

**Constitutional Symptoms**

| | | |
|---|---|---|
| Good general health lately | no | yes |
| Recent weight change | no | yes |
| Fever | no | yes |
| Fatigue | no | yes |
| Headaches | no | yes |

**Eyes**

| | | |
|---|---|---|
| Eye disease or injury | no | yes |
| Wear glasses/contact lenses | no | yes |
| Blurred or double vision | no | yes |

**Ears/Nose/Mouth/Throat**

| | | |
|---|---|---|
| Hearing loss or ringing | no | yes |
| Earaches or drainage | no | yes |
| Chronic sinus problem or rhinitis | no | yes |
| Nose bleeds | no | yes |
| Mouth sores | no | yes |
| Bleeding gums | no | yes |
| Bad breath or bad taste | no | yes |
| Sore throat or voice change | no | yes |
| Swollen glands in neck | no | yes |

**Cardiovascular**

| | | |
|---|---|---|
| Heart Trouble | no | yes |
| Chest pain or angina pectoris | no | yes |
| Palpitation | no | yes |
| Shortness of breath when walking or lying flat | no | yes |
| Swelling of feet, ankles or hands | no | yes |

**Respiratory**

| | | |
|---|---|---|
| Chronic or frequent coughs | no | yes |
| Spitting up blood | no | yes |
| Shortness of breath | no | yes |
| Wheezing | no | yes |

**Gastrointestinal**

| | | |
|---|---|---|
| Loss of appetite | no | yes |
| Change in bowel movements | no | yes |
| Nausea or vomiting | no | yes |
| Frequent diarrhea | no | yes |
| Painful bowel movements or constipation | no | yes |
| Rectal Bleeding or blood in stool | no | yes |
| Abdominal pain | no | yes |

**Genitourinary**

| | | |
|---|---|---|
| Frequent urination | no | yes |
| Burning or painful urination | no | yes |
| Blood in urine | no | yes |
| Change in force of strain when urinating | no | yes |
| Incontinence or dribbling | no | yes |
| Kidney stones | no | yes |
| Sexual difficulty | no | yes |
| Male - testicle pain | no | yes |
| Female - pain with periods | no | yes |
| Female - vaginal discharge | no | yes |
| Female - # of pregnancies | no | yes |
| Female - # of miscarriages | no | yes |
| Female - date of last pap smear | no | yes |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint pain | no | yes |
| Joint stiffness or swelling | no | yes |
| Weakness of muscle or joints | no | yes |
| Muscle pain or cramps | no | yes |
| Back pain | no | yes |
| Cold extremities | no | yes |
| Difficulty in walking | no | yes |

**Integumentary (skin, breast)**

| | | |
|---|---|---|
| Rash or itching | no | yes |
| Change in skin color | no | yes |
| Change in hair or nails | no | yes |
| Varicose veins | no | yes |
| Breast pain | no | yes |
| Breast lump | no | yes |
| Breast discharge | no | yes |

**Neurological**

| | | |
|---|---|---|
| Frequent or recurring headaches | no | yes |
| Light headed or dizzy | no | yes |
| Convulsions or seizures | no | yes |
| Numbness or tingling sensations | no | yes |
| Tremors | no | yes |
| Paralysis | no | yes |
| Head injury | no | yes |

**Psychiatric**

| | | |
|---|---|---|
| Memory loss or confusion | no | yes |
| Nervousness | no | yes |
| Depression | no | yes |
| Insomnia | no | yes |

**Endocrine**

| | | |
|---|---|---|
| Glandular or hormone problem | no | yes |
| Excessive thirst or urination | no | yes |
| Heat or cold intolerance | no | yes |
| Skin becoming dryer | no | yes |
| Change in hat or glove size | no | yes |

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Slow to heal after cut | no | yes |
| Bleeding or bruising tendency | no | yes |
| Anemia | no | yes |
| Phlebitis | no | yes |
| Past transfusion | no | yes |
| Enlarged glands | no | yes |

**Date of Last:**

Mammogram _____

Pap Smear _____

PSA _____

Colonoscopy _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I do authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date