



Tower Surgical

### Medical Health History Form

<b>Patient Name</b> (Last, First, MI)	<b>Male</b>	<b>Birthdate</b> (mm/dd/yy)	<b>Age</b>	<b>Social Security No.</b>
	<b>Female</b>			

Pharmacy Information		
Preferred Pharmacy Name	Address	Telephone

History of Present Illness
<b>Why are you being seen today?</b> _____
<b>How long have you had this problem?</b> _____
<b>What are your symptoms?</b> _____ _____

<b>What tests have you had done in relation to this problem?</b> <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Xray <input type="checkbox"/> UpperGI <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Other Please List: _____
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<b>Pain Evaluation</b>  Please circle the number that indicates how severe your pain is for this problem. A score of 0 indicates no pain and a score of 10 indicates that this is the worst pain you have ever had. No Pain    [ 0    1    2    3    4    5    6    7    8    9    10 ]    Worst Pain Ever
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<b>Has the problem worsened since it first appeared?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  <b>If Yes, Describe:</b> _____
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<b>Please list any previous treatments you may have received for this problem:</b>  _____ _____ _____
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Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

Review of Systems					
Please check all symptoms that you are having right now.					
General	X	Note	Skin	X	Note
Fever			Change in moles or scars		
Chills			Hives		
Night Sweats			<b>Neck</b>		
Weight Loss			Neck Mass		
Weight Gain			Neck Pain/Stiffness		
Appetite Loss			Swollen Glands		
Fatigue			<b>Breast</b>		
<b>HEENT</b>			Breast Mass		
Headache			Breast Pain		
Vertigo – spinning Sensation			Breast Swelling		
<b>Respiratory</b>			Nipple Discharge		
Cough - Dry/Mucous/Blood			Nipple Pain		
Difficulty Breathing			<b>Gastrointestinal</b>		
Wheezing			Abdominal Mass		
<b>Cardiovascular</b>			Abdominal Pain		
Angina – chest pain w/activity			Bloody Stool / Rectal Bleeding		
Fainting/Blacking Out			Constipation		
Irregular Heart Beat			Diarrhea		
Swelling of Extremities			Difficulty Swallowing		
Palpitations			Heartburn		
Shortness of Breath			Jaundice		
Blood Clots - Leg/Lung			Nausea		
			Vomiting		
<b>Urinary</b>			<b>Musculoskeletal</b>		
Blood in Urine			Back Pain		
Change in Bladder Habits			Muscle Pain		
Flank Pain			<b>Psychiatric</b>		
Painful Urination			Anxiety		
Pelvic Pain			Treatment for Mental Illness		
Bladder / Kidney Infection			<b>Hematology</b>		
Enlarged Prostate/Prostate Cancer			Abnormal Bleeding		
<b>Neurological</b>			Blood Clots		
Dizziness / Fainting			Enlarged Lymphnodes		
TIA – Mini Stroke					
CVA - Stroke			<b>Other</b> (please specify):		
<b>Endocrine</b>					
Excessive Urination					
Thyroid Problems					
Steroid/Prednisone Use					
<b>Gynecologic</b>					
Excessive Bleeding					
Menstrual Irregularities					
Pregnancy					
Menopausal					





Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Patient Past Medical History (Continued)**

I have reviewed this information and I have no past medical history to report.

**Please Check All That Apply :**

	X	Note		X	Note
<b>Skin</b>			<b>Infectious Disease</b>		
Psoriasis			HIV+		
Skin Cancer			AIDS		
<b>Hematologic</b>			VRE		
Anemia			MRSA		
Blood Transfusion			Tuberculosis		
Hemophilia			<b>Mental Health</b>		
VonWillabrand Disease			Depression		
			Treatment for Mental Illness		
			Chemical Dependency		

**Past Surgical History**

I have reviewed this information and I have no past surgical history to report.

<b>Head and Neck Surgery</b>	X	Please indicate year surgery was performed
Tonsillectomy		
Nasal Surgery		
Sinus Surgery		
Surgery for Sleep Apnea		
Thyroid Surgery		
<b>Breast Surgery</b>		
Breast Biopsy		<input type="checkbox"/> Right <input type="checkbox"/> Left
Breast Lumpectomy		<input type="checkbox"/> Right <input type="checkbox"/> Left
Mastectomy		<input type="checkbox"/> Right <input type="checkbox"/> Left
Breast Augmentation		
Breast Reconstruction		<input type="checkbox"/> Right <input type="checkbox"/> Left
<b>Abdominal/Colon Surgery</b>		
Appendectomy		
Gallbladder		
Hiatal Hernia/Reflux Surgery		
Weight Loss Surgery		
Stomach Surgery for an ulcer		
Surgery for adhesions		
Partial Colon Removal		<input type="checkbox"/> Tumor <input type="checkbox"/> Diverticulitis
Hemorrhoid Surgery		
Colonoscopy		
Groin Hernia		<input type="checkbox"/> Right <input type="checkbox"/> Left
Umbilical Hernia		<input type="checkbox"/> Right <input type="checkbox"/> Left
Incisional Hernia		

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Past Surgical History (Continued)**

I have reviewed this information and I have no past surgical history to report.

<b>Cardiovascular Procedures/Surgery</b>	<b>X</b>	
Stress Test – Treadmill or Chemical		
Heart Catherization		
Cardiac Angioplasty		
Cardiac Stents		
Cardiac Bypass Surgery		
Cardiac Valve Replacement		
Pacemaker		
Implantable Defibrillator		
Aortic Aneurysm Repair		
Carotid Repair		<input type="checkbox"/> Right <input type="checkbox"/> Left
Vascular Bypass		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Abdominal
<b>Gynecology/Urology</b>		
Hysterectomy		
Caesarean Section		
Tubal Ligation		
Ovary Removal		
Bladder Suspension		
Laparoscopy		
Cystoscopy		
Prostate Surgery		
Kidney Stone Crushing - Lithotripsy		
Kidney Removal		

**Other Illnesses, Hospitalizations, or Operations (not listed above)**

Year	Place	Illness, Injury, Operation	Doctor

Do you have any surgical implants or metal inside your body?  No  Yes

Location: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Social History**

**Current Work Status:**     Full-Time     Part-Time     Retired     Disabled     Unemployed     Student

**Occupation of Profession (of patient):** \_\_\_\_\_

**Do you exercise regularly?**     No     Yes    What Type? \_\_\_\_\_

**Marital Status:**     Single     Married     Separated     Divorced     Widowed

**Name of Spouse/Significant Other:** \_\_\_\_\_

**Any Travel Out of the Country in the past 12 months?**     No     Yes    If yes, where? \_\_\_\_\_

Substances	No	Yes	Frequency/Amount	When did you start?	When did you stop?
Cigarettes					
Cigars					
Pipes					
Chewing Tobacco					
Alcohol					
Caffeine					
Cocaine					
Marijuana					
Heroin					
Methamphetamine					
Narcotics					
Sedatives					

**Vitals**

Current Weight	_____ lbs	Current Height	_____ ft. _____ in.
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**Physicians involved in your Care**

	Name	Address	Telephone
<b>Referring Physician</b>			
<b>Family Physician</b>			
<b>Other Physicians</b>			