GENERAL SURGERY HEALTH QUESTIONNAIRE

______________________	______________________	________	______________________
Patient Name	Patient Date of Birth	Age	Today's Date

______________________	______________________
Name of Referring Doctor	Name of Primary Care Provider
______________________	______________________
Patient Email Address	Preferred Pharmacy
______________________	______________________
Preferred Lab	Preferred Imaging Center

CHIEF COMPLAINT(S) AND DATE SYMPTOMS STARTED____

____

IF INJURY, HOW DID INJURY OCCUR?____

HEIGHT________________________ WEIGHT______________________

LIST ANY PAST SURGERIES	DATE	LIST CURRENT MEDICATIONS / DOSAGES	TIMES PER DAY
_______________	__________	_______________	_______
_______________	__________	_______________	_______
_______________	__________	_______________	_______
_______________	__________	_______________	_______

DO YOU SMOKE? ☐ Yes AMOUNT _________ ☐ No FORMER SMOKER? ☐ Yes ☐ No HOW LONG DID YOU SMOKE? _______________

DO YOU CONSUME ALCOHOL? ☐ Yes ☐ No AMOUNT_______________

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No

CHECK ANY PAST ILLNESSES

☐ Cancer	☐ Asthma	☐ Hypertension	☐ Heart Disease	☐ Diabetes	☐ Bronchitis
☐ Rheumatic Fever	☐ Kidney Problems	☐ Stroke	☐ Hepatitis	☐ Tuberculosis	☐ Drug Problem
☐ Epilepsy	☐ Pancreatitis	☐ Thyroid Problem	☐ Clotting Problems	☐ Liver Problems	

Do you have religious beliefs that influence your medical decisions? ☐ Yes ☐ No

Do you have someone who loves and cares for you? ☐ Yes ☐ No ☐ Not Sure

Do you have a source of joy in your life? ☐ Yes ☐ No ☐ Not Sure

Do you have a sense of peace today? ☐ Yes ☐ No ☐ Not Sure

LIST ANY OTHER MEDICAL PROBLEMS ____

____

LIST ANY ALLERGIES ____

____

GENERAL SURGERY HEALTH QUESTIONNAIRE

FAMILY HEALTH HISTORY

MOTHER

- [ ] Alcohol Abuse
- [ ] Alzheimer's Disease
- [ ] Arthritis
- [ ] Asthma
- [ ] Autism
- [ ] High Blood Pressure
- [ ] Cancer
- [ ] COPD
- [ ] Depression
- [ ] Diabetes
- [ ] Thyroid Disorder
- [ ] High Cholesterol
- [ ] Heart Disease
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Stroke

FATHER

- [ ] Alcohol Abuse
- [ ] Alzheimer's Disease
- [ ] Arthritis
- [ ] Asthma
- [ ] Autism
- [ ] High Blood Pressure
- [ ] Cancer
- [ ] COPD
- [ ] Depression
- [ ] Diabetes
- [ ] Thyroid Disorder
- [ ] High Cholesterol
- [ ] Heart Disease
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Stroke

GRANDMOTHER (Please indicate Maternal or Paternal)

- [ ] Alcohol Abuse
- [ ] Alzheimer's Disease
- [ ] Arthritis
- [ ] Asthma
- [ ] Autism
- [ ] High Blood Pressure
- [ ] Cancer
- [ ] COPD
- [ ] Depression
- [ ] Diabetes
- [ ] Thyroid Disorder
- [ ] High Cholesterol
- [ ] Heart Disease
- [ ] Obesity
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- [ ] Stroke

GRANDFATHER (Please indicate Maternal or Paternal)

- [ ] Alcohol Abuse
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- [ ] High Blood Pressure
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- [ ] Depression
- [ ] Diabetes
- [ ] Thyroid Disorder
- [ ] High Cholesterol
- [ ] Heart Disease
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Stroke

SISTER

- [ ] Alcohol Abuse
- [ ] Alzheimer's Disease
- [ ] Arthritis
- [ ] Asthma
- [ ] Autism
- [ ] High Blood Pressure
- [ ] Cancer
- [ ] COPD
- [ ] Depression
- [ ] Diabetes
- [ ] Thyroid Disorder
- [ ] High Cholesterol
- [ ] Heart Disease
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Stroke

BROTHER

- [ ] Alcohol Abuse
- [ ] Alzheimer's Disease
- [ ] Arthritis
- [ ] Asthma
- [ ] Autism
- [ ] High Blood Pressure
- [ ] Cancer
- [ ] COPD
- [ ] Depression
- [ ] Diabetes
- [ ] Thyroid Disorder
- [ ] High Cholesterol
- [ ] Heart Disease
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Stroke