MLHC Surgical Associates

Patient Health Questionnaire

Name:______________________ DOB:__________ Date:__________

Age:________ Height:________ Weight:________ Reason for Visit?______________________

Referring Provider:

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Address: ____________________

____

Phone: (   )____________________

Family Doctor:____________________

Phone: (   )____________________

Cardiologist:____________________

Phone: (   )____________________

Other:____________________

Phone: (   )____________________

Medications

Please list your medications with dosages (include all prescription, non-prescription and herbal treatments).

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Allergies/Reaction

Please list any allergies including those to drugs, latex, adhesive tape, food, etc. and include your reaction:

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Have you had any of the following?
Please check appropriate boxes.

Past Medical History

- ☐ High Blood Pressure
- ☐ Acute Myocardial Infarction
- ☐ A-Fib
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Venous Thrombosis (DVT)
- ☐ Cancer Type:____________________
- ☐ High Cholesterol
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder Type:____________________
- ☐ Esophageal Reflux
- ☐ Seizure Disorder
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ Renal Failure
- ☐ Blood Disorder Type:____________________
- ☐ HIV Infection
- ☐ Hepatitis
- ☐ Other____________________

Social History

Current Smoker: ☐ Y ☐ N
Packs per day?_ No. of years?______

Former Smoker: ☐ Y ☐ N
Year you quit:____________________

Other Tobacco Use? ☐ Y ☐ N Type?__________
____

Alcohol Use: ☐ Y ☐ N Frequency?__________
____

Recreational Drug Use: ☐ Y ☐ N
Type/frequency?____________________

Name: ______________________________ Date: ____________________

Family History

Cancer: ☐ Y ☐ N Type:____________________
Relationship:____________________

Heart Disease: ☐ Y ☐ N Relationship:__________

High Blood Pressure: ☐ Y ☐ N Relationship:__________

Diabetes Mellitus: ☐ Y ☐ N Relationship:__________

Other: ☐ Y ______________________________

Past Surgical History

Please list the date and type of any previous surgery:

____
____
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Have you ever had a problem with anesthesia?
(please explain)

____
____
____

Have any of your family members ever had a problem with anesthesia? (please explain)

____
____
____

Do you currently have any of the following?

Allergies:

☐ Y ☐ N

General Symptoms

☐ Y ☐ N Weight Change
If yes, indicate gained or lost?__________
Amount?____________________
☐ Y ☐ N Increase in Appetite
☐ Y ☐ N Decrease in Appetite
☐ Y ☐ N Fever
☐ Y ☐ N Chills
☐ Y ☐ N Tiring Easily

Skin Symptoms

☐ Y ☐ N Itching
☐ Y ☐ N Skin Lesions
☐ Y ☐ N Rashes
☐ Y Other:____________________

Eye Symptoms

☐ Y ☐ N Vision Problems
☐ Y ☐ N Corrective Lenses
☐ Y Other:____________________

Neck Symptoms

☐ Y ☐ N Neck Pain
☐ Y ☐ N Neck Stiffness
☐ Y ☐ N Lump or Swelling
☐ Y Other:____________________

Otolaryngeal Symptoms

☐ Y ☐ N Earache
☐ Y ☐ N Hearing Loss
☐ Y ☐ N Nosebleeds
☐ Y ☐ N Mouth Sores
☐ Y ☐ N Bleeding Gums
☐ Y ☐ N Hoarseness
☐ Y ☐ N Throat Pain
☐ Y Other:____________________

Name:______________________________ Date:__________________

Cardiovascular

- ☐ Y ☐ N Chest Pain or Discomfort
- ☐ Y ☐ N Fast Heart Rate
- ☐ Y ☐ N Palpitations
- ☐ Y Other:______________________

Pulmonary Symptoms

- ☐ Y ☐ N Wheezing (Asthma)
- ☐ Y Other:______________________

Endocrine Symptoms

- ☐ Y ☐ N Excessive Sweating
- ☐ Y ☐ N Excessive Thirst
- ☐ Y Other:______________________

Hematologic Symptoms

- ☐ Y ☐ N Easy Bleeding
- ☐ Y ☐ N Easy Bruising Tendency
- ☐ Y Other:______________________

Gastrointestinal Symptoms

- ☐ Y ☐ N Difficulty Swallowing
- ☐ Y ☐ N Heartburn
- ☐ Y ☐ N Ulcer
- ☐ Y ☐ N Nausea
- ☐ Y ☐ N Vomiting
- ☐ Y ☐ N Abdominal Pain
- ☐ Y ☐ N Bowel/Bladder Changes
- ☐ Y ☐ N Diarrhea
- ☐ Y ☐ N Constipation
- ☐ Y ☐ N Black or Tarry Stools
- ☐ Y ☐ N Rectal Bleeding
- ☐ Y Other:______________________

Genitourinary Symptoms

- ☐ Y ☐ N Pain During Urination
- ☐ Y ☐ N Increased Urinary Frequency
- ☐ Y ☐ N Blood in Urine
- ☐ Y ☐ N Genital Lesion
- ☐ Y Other:______________________

Musculoskeletal Symptoms

- ☐ Y ☐ N Joint Pain
- ☐ Y ☐ N Joint Stiffness
- ☐ Y ☐ N Muscle Aches
- ☐ Y Other:______________________

Neurological Symptoms

- ☐ Y ☐ N Dizziness
- ☐ Y ☐ N Veritgo
- ☐ Y ☐ N Fainting
- ☐ Y ☐ N Motor Disturbances
- ☐ Y ☐ N Sensory Disturbances
- ☐ Y Other:______________________

Psychological Symptoms

- ☐ Y ☐ N Sleep Disturbances
- ☐ Y ☐ N Anxiety
- ☐ Y ☐ N Depression
- ☐ Y Other:______________________

Female Patients Only:

Date of Last Menstrual Period__________________

Screening and Immunization History

(All patients)

Did you receive a flu vaccination during last year's flu season (October - March)? ☐ Y ☐ N

Approximate Date______________

*Surgical Specialists' physicians recommend you obtain an annual flu vaccine.

(All patients ages 50-75)

When was your last colonoscopy?______________

*Surgical Specialists' physicians recommend you have a screening colonoscopy every 10 years unless otherwise indicated by your family doctor or specialist.

(Female patients age 40 or older)

When was you last mammogram?______________

*Surgical Specialists' physicians recommend you have a yearly screening mammogram.

(All patients age 65 or older)

Have you ever received a pneumonia vaccination?

☐ Y ☐ N Approximate Date______________

*Surgical Specialists' physicians recommend you receive a pneumonia vaccine if you are age 65 or older and have not yet received one.