AVANTÉ
SURGICAL

Medical History Form

Date ____________ Patient Name ______________________________ Age ______ Date of Birth ______________

Other Physicians involved in my care ____

Referred to this office by ____

What areas or issues would you like to discuss today: (Please limit to 3 items)

1.______________________________________ 2.______________________________________

3.____

PREVENTATIVE HEALTH STATUS:

Date of last physical exam: ______________

Have you ever had a colonoscopy or sigmoidoscopy? ☐ yes ☐ no When/Findings: ____________________

Do you have an Advance Directive for health care decisions? ☐ yes ☐ no Power of Attorney ☐ yes ☐ no

Last immunizations: (please give date of most recent vaccination or series completion date)

Tetanus: __________ Hepatitis B: __________ Hepatitis A: __________ HPV: __________ Influenza: __________

Pneumonia: __________ Shingles: __________ TB skin test result: ______________________ Date: __________

FOR WOMEN ONLY:

Date of last period: __________ Last Pap: __________ Age periods began: ______ Age at start of menopause:______

Have you had a mammogram? ☐ yes ☐ no Most recent date __________ Result ____________________

Birth control method: ____

Have you had any pregnancies? ☐ yes ☐ no Total number _________Miscarriages/Abortions ______________

Problems during pregnancies: ____

FOR MEN ONLY:

Have you had a PSA blood test and/or prostate exam? ☐ yes ☐ no Last Date ________ Result________________

SOCIAL HISTORY:

Occupation: ____________________________ Former Regions of Residence: ______________________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Living Situation: ☐ Alone ☐ Roommate ☐ Spouse ☐ Parents ☐ Significant Other ☐ With Children

Have you been in a relationship where you were hurt, threatened or made to feel afraid? ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no How many per week? ________________ Quit/When ______________

Do you use tobacco? ☐ yes ☐ no How much/how long? ________________ Quit/When ______________

Do you drink caffeine? ☐ yes ☐ no How much per day? ______________________________________

Have you used drugs? ☐ yes ☐ no Which ones? ______________________ Quit/When ______________

Do you exercise? ☐ yes ☐ no Type: ____________________ How often? ____________________

Do you follow a diet? ☐ yes ☐ no Please describe: ____________________________________

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PERSONAL MEDICAL HISTORY: Have you ever been diagnosed with the following? (Please check box)

Heart Disease:
- ☐ murmur
- ☐ angina / coronary disease
- ☐ congestive heart failure
- ☐ rheumatic fever
- ☐ valve replacement
- ☐ irregular heartbeat
- ☐ heart attack
- ☐ high blood pressure

Infectious Disease:
- ☐ AIDS or HIV positive
- ☐ MRSA infection
- ☐ tuberculosis
- ☐ sexually transmitted disease

Musculoskeletal:
- ☐ rheumatoid arthritis
- ☐ gout
- ☐ osteoarthritis
- ☐ fibromyalgia

Gynecological:
- ☐ abnormal pap
- ☐ endometriosis
- ☐ fibroids
- ☐ ovarian cysts
- ☐ irregular bleeding

Respiratory:
- ☐ asthma
- ☐ allergies / hay fever
- ☐ emphysema/COPD
- ☐ chronic bronchitis
- ☐ pneumonia
- ☐ asbestos exposure
- ☐ sleep apnea

Gastrointestinal:
- ☐ ulcers
- ☐ colon polyps
- ☐ gallstones
- ☐ hiatal hernia
- ☐ hepatitis, type __________
- ☐ hemorrhoids
- ☐ irritable bowel syndrome
- ☐ colitis
- ☐ diverticulosis
- ☐ gastrointestinal bleeding

Kidney/Bladder:
- ☐ stones
- ☐ prostate disorder
- ☐ incontinence
- ☐ infection

Mental Health/Neurologic:
- ☐ anxiety
- ☐ depression
- ☐ alcoholism
- ☐ drug abuse
- ☐ other mental illness
- ☐ migraines/headaches
- ☐ stroke
- ☐ seizures
- ☐ paralysis

Metabolic/Nutrition:
- ☐ diabetes
- ☐ high cholesterol
- ☐ anemia
- ☐ thyroid problem
- ☐ bleeding disorder

Cancer:
- ☐ breast cancer
- ☐ cervical cancer
- ☐ ovarian cancer
- ☐ colon cancer
- ☐ skin cancer
- ☐ prostate cancer
- ☐ other cancer (type) _________ _________________________

☐ **None of the above**

Have you ever had a blood transfusion? ☐ yes ☐ no If yes, when? ____________________________________

Childhood Illnesses: ____

Hospitalizations, operations, serious illnesses or injuries: (omit pregnancies)

		Date			Date
1.	______________________		**3.**	______________________	
2.	______________________		**4.**	______________________	

Present Medications: (Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs, etc.)

	Name	Dose	Times/Day		Name	Dose	Times/Day
1.				**5.**			
2.				**6.**			
3.				**7.**			
4.				**8.**			

Drug Allergies:

	Medication	Type of Reaction		Medication	Type of Reaction
1.			**3.**		
2.			**4.**		

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FAMILY HISTORY

Relation	If Living: Age	If Deceased: Age at Death	Illness or Cause of Death
Father			
Mother			
Brother or sister			
1.			
2.			
3.			
4.			
5.			

Has any of your immediate family ever had: (if yes, indicate relationship and age of onset)

Allergy/Asthma	Arthritis/Gout
Cancer Type:	Depression/Mental Illness Type:
Skin Canser Type:	Epilepsy/Seizures
Inflammatory Bowel Disease	Heart Disease/Coronary Artery Disease
High Blood Pressure	Liver Disease
Kidney Disease	Diabetes
Alcohol/Substance Abuse	Migraine Headaches
Overweight	High Cholesterol
Stroke	Thyroid Disease
Tuberculosis	Gastric Ulcers
Bleeding Disorder	Colon Polyps

Trouble with Anesthesia: ____

Other family medical history: ____

For Clinician Use

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AVANTÉ SURGICAL

Medical History Form

Today's Date ____________ **Patient Name** ________________________________ **Date of Birth** _______________

REVIEW OF SYSTEMS: Check any of the following symptoms you are CURRENTLY EXPERIENCING

GENERAL:
- ☐ change in heat & cold tolerance
- ☐ persistent fever
- ☐ chills/cold intolerance
- ☐ excess appetite
- ☐ increased thirst
- ☐ lack of appetite
- ☐ night sweats
- ☐ swollen glands
- ☐ unusual weakness
- ☐ unusual fatigue
- ☐ weight change
  increase ___
  decrease ___
- ☐ Other _____________
- ☐ **None of the above**

ALLERGY:
- ☐ sneezing
- ☐ environmental allergy
- ☐ food allergy __________
- ☐ Other _____________
- ☐ **None of the above**

SKIN:
- ☐ ulcers
- ☐ bruise easily
- ☐ change in skin or mole
- ☐ dryness of skin
- ☐ rash or hives
- ☐ nail change
- ☐ unusual hair loss
- ☐ Other _____________
- ☐ **None of the above**

EYES:
- ☐ eye pain
- ☐ blind spells (in one eye)
- ☐ change in vision
- ☐ contact lenses
- ☐ eye infection
- ☐ wear glasses
- ☐ Other _____________
- ☐ **None of the above**

EARS/NOSE/THROAT:
- ☐ earache
- ☐ hearing loss
- ☐ ear infection or drainage
- ☐ ringing in ears
- ☐ bleeding gums
- ☐ hoarseness
- ☐ neck swelling/lumps
- ☐ sores in mouth
- ☐ nose bleeds
- ☐ nasal polyps
- ☐ sinus trouble
- ☐ Other _______________
- ☐ **None of the above**

BREASTS:
- ☐ discharge/bleeding
- ☐ nipple changes
- ☐ lump
- ☐ pain
- ☐ Other _______________
- ☐ **None of the above**

HEART:
- ☐ white, blue or purple discoloration of hands or feet
- ☐ calf pain when walking
- ☐ chest discomfort/pain
- ☐ irregular heart beat
- ☐ racing or fluttering heart
- ☐ swollen feet or ankles
- ☐ varicose veins
- ☐ Other _______________
- ☐ **None of the above**

LUNGS:
- ☐ shortness of breath
- ☐ persistent cough
- ☐ wheezing
- ☐ cough up blood
- ☐ cough up phlegm
- ☐ difficulty breathing
- ☐ **None of the above**

GASTROINTESTINAL:
- ☐ belching
- ☐ bloody or black stools
- ☐ change in stools
- ☐ constipation
- ☐ difficult swallowing
- ☐ excessive gas
- ☐ food intolerance
- ☐ heartburn/esophageal reflux
- ☐ hemorrhoids
- ☐ loose bowels/diarrhea
- ☐ nausea
- ☐ recurrent abdominal pain
- ☐ vomiting
- ☐ Other _______________
- ☐ **None of the above**

URINARY:
- ☐ change in urinary stream
- ☐ blood in urine
- ☐ difficulty urinating
- ☐ frequency
- ☐ leaking urine
- ☐ pain or burning on urination
- ☐ unusually large volumes of urine
- ☐ up at night to urinate? how often? __________
- ☐ incontinence
- ☐ sexual difficulty
- ☐ Other _______________
- ☐ **None of the above**

FEMALE:
- ☐ heavy menstrual bleeding
- ☐ irregular menstrual periods
- ☐ discharge
- ☐ premenstrual symptoms
- ☐ Other _______________
- ☐ **None of the above**

BONES AND JOINTS:
- ☐ back or neck pain
- ☐ cramps in muscles
- ☐ painful or stiff joints
- ☐ pain down backs of legs
- ☐ pain in legs with walking
- ☐ swelling in legs
- ☐ redness of joints
- ☐ Other _____________
- ☐ **None of the above**

MOOD/MENTAL HEALTH:
- ☐ depressed or sad
- ☐ irritable or angry
- ☐ anxious, tense, or worried
- ☐ fearful
- ☐ sleep problems
- ☐ loss of interest in activities
- ☐ fatigue
- ☐ suicidal thoughts
- ☐ compulsive behaviors
- ☐ concentration/memory problems
- ☐ marital, family or work problems
- ☐ stress
- ☐ Other _____________
- ☐ **None of the above**

NEUROLOGIC:
- ☐ coordination problems
- ☐ difficulties in speaking
- ☐ dizziness
- ☐ fainting spells
- ☐ frequent headaches
- ☐ loss of balance
- ☐ loss of sensation
- ☐ muscle weakness
- ☐ numbness or tingling
- ☐ Other _____________
- ☐ **None of the above**

For Clinician Use

Reviewed by **Date**

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