Date____________

Puyallup Surgical Consultants

Personal Medical Questionnaire

Please answer all the questions to the best of your ability. As major surgery may be considered, please be accurate and complete.

Personal Information

Name____ Age __________

Family Doctor ____

Please List Medical Conditions currently being treated or of past significance

1 ____
2 ____
3 ____
4 ____
5 ____

ALLERGIES: Please list the drugs you are allergic to, and what happens.

1 ____
2 ____
3 ____
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List All Current medications and dose

1 ______________________________
2 ______________________________
3 ______________________________
4 ______________________________
5 ______________________________
6 ______________________________
7 ______________________________
8 ______________________________

List all Prior Surgeries and approximate dates

1 ______________________________
2 ______________________________
3 ______________________________
4 ______________________________
5 ______________________________
6 ______________________________
7 ______________________________
8 ______________________________

Family history: Please note if you know of a medical problem in any of your grandparents, parents, brothers/sisters, or children

Cancer (type?) ______________________________________
Heart disease ______________________________________
Anesthesia Problems ______________________________________
Bleeding Disorder ______________________________________
Other (list) ______________________________________

Personal habits

Do you smoke? YES NO How many packs a day?___________

Did you smoke in the past and quit? YES NO

How many years did you smoke?________________

Do you drink alcohol? YES NO Average drinks per day___________

Do you drink heavily in the past and quit? YES NO

Do you use recreational drugs? YES NO Which ones?____________________

Are you presently or in the past engaged in any activities that may place you at risk for AIDS, including, IV Street Drugs, Blood transfusion, Prostitution, Homosexuality, Multiple sexual partners? YES NO

Social History

Employment ____

Highest Education____

Hobbies ____

Religious Preference____

Number of children____

Current living situation: (Circle answer) Home Nursing Home With Family Other

What is your Marital Status? (Circle answer) Married Divorced Single Widow Significant Other

Please circle the problems or conditions that you have or may have had in the past

Diabetes	Hospitalization for lung disease
Emphysema	Ulcers
Hypertension	AIDS/HIV
Seizure	Cancer
Problems with anesthesia	Cirrhosis of the liver
Problem with bleeding	Gall bladder disease
Anemia	Steroid use (eg. Prednisone)
Heart attack	Problem with iodine or seafood

Females Only

Are your periods regular? YES NO When was your last period?______________

Are you having a problem with your periods? YES NO

Have you ever taken birth control pills? YES NO

Are you on hormone replacement? YES NO

Children Only

Are you up to date on your immunizations? YES NO

Are there special problems you are having at school or home? YES NO

Review of Systems

Please check those items that are true for you <u>at this time</u>.

Constitutional

- ☐ Are you having a problem with **fever or chills**?
- ☐ Do you notice **nightsweating**?
- ☐ Have you gained more than 10 lbs in the last 6 months?
- ☐ Have you lost more the 10 lbs in the last 6 months?
- ☐ Did you ever have an **eating disorder**?

Heart

- ☐ Do you have occasional **chest pain**?
- ☐ Do your feet swell during the day?
- ☐ Have you ever had an **irregular heartbeat**?
- ☐ Have you ever had **an abnormal EKG**?
- ☐ Have you ever been told you have a **heart murmur**?

Lungs

- ☐ Do you have a **cough**?
- ☐ Do you have a problem with **shortness of breath**?
- ☐ Have you ever **coughed up blood**?
- ☐ Do you have **asthma**? Have you ever had asthma?
- ☐ Have you ever had blood clots go to your lungs?

Digestive

- ☐ Are you experiencing a **loss or decrease** in your **appetite**?
- ☐ Have you had a change in your bowel habits?
- ☐ Are you having **belly pain** or belly cramps?
- ☐ Have you ever **vomited up blood**?
- ☐ Have you ever had **blood in your stool**?
- ☐ Have your **stools been black**?

Urinary

- ☐ Do you have difficult or **painful urination**?
- ☐ Has your **urine been bloody**?
- ☐ Do you wake up more than once to urinate at night?
- ☐ Do you have **difficulty starting the stream** of urine?
- ☐ If you cough or sneeze, do you wet your clothes?

Eyes, ears, nose, mouth, throat

- ☐ Do you have a problem with **hay fever**?
- ☐ Do you usually wear eye **glasses or contacts**?
- ☐ Do you have **glaucoma**?
- ☐ Do you wear **false teeth**? Partials? Dentures?
- ☐ Do you have **hoarseness** without pain?

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Circulatory

- ☐ Do you get **leg cramping** when you walk?
- ☐ Has just one of your feet ever swelled?
- ☐ Have you ever had a stroke?

Neurologic/musculo-skeletal

- ☐ Do you have a problem with **fainting**?
- ☐ Do you get headaches easily?
- ☐ Do you have a problem with **numbness** in your hands or feet?
- ☐ Do you have **joint problems** like stiff joints?
- ☐ Have you ever been **paralyzed**?
- ☐ Do you have a problem with **muscle weakness**?
- ☐ Have you ever had a problem with **seizures**?

Immunologic/hematologic/lymphatic

- ☐ Have you ever had a **blood transfusion**?
- ☐ Do you bleed excessively, or have a **bleeding tendency**?
- ☐ Do you have a problem with your "glands" **(lymph nodes) swelling**?
- ☐ Are there any types of recurring **infections** you have a problem with?

Endocrine

- ☐ Do you get **excessively hot or cold** as compared to other people?
- ☐ Have you ever had a **goiter** or thyroid problems?

Skin

- ☐ Do you have a problem with a **rash**?
- ☐ Do you have any major **skin diseases**?
- ☐ Do you have any **skin infections**?

Psychiatric

- ☐ Have you ever had **mental health treatment**?
- ☐ Do you have **emotional problems**?
- ☐ Do you have a problem with **chemical dependency**?
- ☐ Have you been treated for **drug or alcohol problems**?
- ☐ Are you taking medication for depression?

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Thank you for taking the time to complete this form. We reassure you that the answers will be held in strict confidence. Your efforts will be most helpful in allowing us to provide you the best possible medical care.