LIBERTY SURGICAL ASSOCIATES, PLLC

MEDICAL HISTORY QUESTIONNAIRE DATE:_____

Name_____

Birthdate_____ Age_____
Occupation_____
Height_____Weight_____
Single married widowed divorced
children_____# pregnancies_____
Reason for visit today:_____
_____
Have you seen another surgeon for this? Y or N
If Yes, whom?_____
Pharmacy and location that you use:
_____
List any **allergies** to medication/**Latex** Yes or No
_____
_____
List **PAST SURGERIES/COLONOSCOPY** :
Example: appendectomy 1980
_____
_____
_____
_____
Colonoscopy? No Yes, date?_____
Mammogram? No Yes, date?_____
List all medications/dose/ (*including herbals*):
_____
_____
_____
_____
_____

Do you use **Aspirin**/dose?_____
Are you a **smoker**? Yes or No
If yes, how many packs a day?_____
how may years?_____
If you quit, how long ago?_____
Do you use **alcohol**? Yes or No
If yes, how many drinks a week?_____
How many **coffee/tea/pops** per day?_____
Do you use **recreational drugs**? Yes or No
If yes, which ones?_____

PAST MEDICAL HISTORY

Problem with anesthesia?	**Yes**	**No**
High Blood Pressure	Yes	No
Heart Disease- Angina	Yes	No
Irregular Heartbeat	Yes	No
Heart Murmur	Yes	No
Mitral Valve Prolapse	Yes	No
- preop antibiotics	Yes	No
HIV/AIDS	Yes	No
Lung Disease- Asthma	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
- if yes, when?_____		
Sleep Apnea	Yes	No
Diabetes	Yes	No
Psychiatric- Anxiety	Yes	No
Depression	Yes	No
Nervous System – Stroke	Yes	No
- if yes, when?_____		
Seizure Disorder	Yes	No
- if yes, last one?_____		
Bleeding/Clotting disorder	Yes	No
Gastrointestinal Disease		
Stomach Ulcers	Yes	No
- if yes, H.pylori?	Yes	No
Hiatal Hernia	Yes	No
Gallstones	Yes	No
Colitis	Yes	No
Diverticulitis	Yes	No
Hepatitis	Yes	No
Kidney Disease- Infections	Yes	No
Stones	Yes	No
Cancer	Yes	No
What type?_____		
Thyroid Disease	Yes	No
Other medical problems?	Yes	No

Please list_____
_____
_____
_____

FAMILY HISTORY

Please answer the following questions based on your Grandparents, Parents, Brothers, Sisters, Children

Check if anyone with:	Which family member (s):
_____Heart Disease	_____
_____Diabetes	_____
_____Colon Cancer	_____
_____Colon Polyps	_____
_____Thyroid Disease	_____
_____Bleeding Disorder	_____
_____Clotting Disorder	_____
_____Pancreatic Cancer	_____
_____Skin Cancer	_____
_____Uterine Cancer	_____
_____Ovarian Cancer	_____
_____Breast Cancer	_____
_____BRCA 1-2 positive	_____
_____Other Cancer	_____
If yes, what type?	_____

Father- Age if living	_____	Mother- Age if living	_____
Age if deceased	_____	Age if deceased	_____
Cause of death	_____	Cause of death	_____

Siblings-How many *brothers*?	_____
Age when deceased	_____
Cause of death	_____
How many *sisters*?	_____
Age when deceased	_____
Cause of death	_____

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