Banner Health **Sun City General Surgery Specialists** **Patient History Information**

PATIENT NAME_____ **DATE**_____

OCCUPATION: (**If Retired, list previous occupation) _____

PRESENT MEDICATIONS, including dosage: _____

_____

_____

HERBS / NATURAL PRODUCTS, including dosage: _____

Do you require prophylactic antibiotics? _____Yes _____No Explain:_____

ALLERGIC TO: MEDICATIONS _____

IODINE (Includes sensitivity to shellfish)**:** ___Yes ___No

LATEX (Includes sensitivity to avacado, banana, kiwi)**:** ___Yes* ___No *Confirmatory Lab Results Required for Surgery

OTHER ALLERGIES: _____

PAST MEDICAL HISTORY (If NOT CURRENT, state year of last episode – If current condition, please note on reverse):

_____MRSA (Methicillin Resistant Staph Aureus) _____Other Infectious Process (Specify)_____

_____High Blood Pressure _____Stroke _____Hemorrhoids

_____Congestive Heart Failure _____Seizure _____Hernia-Type:_____

_____Heart Attack _____Bleeding Ulcer _____Blood Clot – Leg: __Right __Left

_____Cancer: Include location(s) and treatment(s):_____

Other:_____

SURGERIES (List ALL surgeries and dates) _____

_____

_____

_____

Do You Have Any Metal In Your Body? _____Yes _____No **Do you have a Pacemaker?** _____Yes _____No

INJURIES (Include year) _____

_____

SOCIAL:

Tobacco: _____Yes _____No Type:_____ Quantity_____

Quit (year):_____

Alcohol: _____Yes _____No Quantity _____

Other Substance: _____Yes _____No Specify:_____

Quit (year):_____ Rehab:_____

FAMILY HISTORY -- If living, give present age and health status. If deceased, give age at death, and cause.

	Living (Current Age)	Deceased (Age when expired)	List any health conditions (and cause of death, if appropriate) i.e. Diabetes, Heart Disease, Cancer, Tuberculosis, etc.
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			

REVIEW OF SYSTEMS (Please answer EACH question pertaining to CURRENT health conditions)

_____Height _____Weight

		INTEGUMENTARY	
_____Yes	_____No	Skin Condition	
		Specify: _____	
		ENDOCRINE	
_____Yes	_____No	Diabetes Mellitus	
_____Yes	_____No	Hypoglycemia	
_____Yes	_____No	Thyroid Disease	
_____Yes	_____No	Recent Weight Gain	
_____Yes	_____No	Recent Weight Loss	
		HEENT	
_____Yes	_____No	Hearing Difficulty	
_____Yes	_____No	Double Vision	
_____Yes	_____No	Wear Glasses	
_____Yes	_____No	Glaucoma	
_____Yes	_____No	Cataracts ___Right ___Left	
_____Yes	_____No	Abnormal Smelling Function	
		HEMATOLOGICAL	
_____Yes	_____No	Anemia	
_____Yes	_____No	Leukemia	
		CARDIAC	
_____Yes	_____No	Recent Chest Pain	
_____Yes	_____No	High Blood Pressure	
_____Yes	_____No	Low Blood Pressure	
_____Yes	_____No	Irregular Rhythm	
_____Yes	_____No	Rapid Heart Rate	
_____Yes	_____No	Congestive Heart Failure	
_____Yes	_____No	Mitral Valve Prolapse	
		VASCULAR	
_____Yes	_____No	Swelling of Legs	
_____Yes	_____No	Varicose Veins	
		CHEST	
_____Yes	_____No	Discharge From Breast(s)	
_____Yes	_____No	Lump or Mass	
_____Yes	_____No	Tenderness	
		PULMONARY	
_____Yes	_____No	Shortness of Breath	
_____Yes	_____No	Asthma	
_____Yes	_____No	Emphysema	
_____Yes	_____No	Bloody Cough	
		GASTROINTESTINAL	
_____Yes	_____No	Constipation	
_____Yes	_____No	Difficulty Controlling Bowels	
_____Yes	_____No	Bloody or Black Stool	
_____Yes	_____No	Hemorrhoids	
_____Yes	_____No	Ulcers _____	
_____Yes	_____No	Hepatitis ___A ___B ___C	

ENTER DATE OF LAST EXAM AND LOCATION:

PHYSICAL EXAM
Date:_____
Physician:_____

COLONOSCOPY
Date:_____
Location:_____

CHEST X-RAY
Date:_____
Location:_____

URINALYSIS
Date:_____
Location:_____

BLOOD WORK
Date:_____
Location:_____

		GENITOURINARY
_____Yes	_____No	Difficulty Urinating
_____Yes	_____No	Incontinence
_____Yes	_____No	Bloody Urine
_____Yes	_____No	Renal Failure
		MUSCULO / SKELETAL
_____Yes	_____No	Joint Pain
_____Yes	_____No	Muscle Cramps
_____Yes	_____No	Atrophy
_____Yes	_____No	Osteoarthritis
_____Yes	_____No	Osteoporosis
_____Yes	_____No	Scoliosis
_____Yes	_____No	Fracture(s)_____
		IMMUNOLOGICAL
_____Yes	_____No	Scleroderma
_____Yes	_____No	Lupus
_____Yes	_____No	Rheumatologic Disease
_____Yes	_____No	MRSA_____
_____Yes	_____No	Other Infectious Process
		Specify:_____
		NEUROLOGICAL
_____Yes	_____No	Stroke
_____Yes	_____No	Seizures
_____Yes	_____No	Memory Problems
_____Yes	_____No	Multiple Sclerosis
_____Yes	_____No	Parkinson's Disease
		PSYCHOLOGICAL
_____Yes	_____No	Depression
_____Yes	_____No	Nervous
_____Yes	_____No	Claustrophobic

The above information is complete and accurate as stated to the best of my knowledge:

Patient (or Representative) Signature: _____Date_____
(**NOTE:** If signed by representative, reason:_____.)

The above information has been discussed with patient and/or representative:

(1/2011) **Physician Signature:_____ Date_____**

Jonathan Goodman, M.D.