

**Surgical Institute of Reading
HEALTH HISTORY**

Date of Procedure: _____ **Procedure:** _____

Surgeon: _____ **Family/Referring Physician:** _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Address: _____

Home Phone: _____ **Work Phone:** _____

Social Security Number: _____ **Male () Female ()**

Primary Care/Family Physician: _____

Height: _____ **Weight:** _____

Are you Allergic to any medications? () Yes () No (List all medications and reactions)

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies? () Yes () No (List allergy and reaction)

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Are you sensitive to rubber or latex products? () Yes () No

Reaction: _____

Presently used Medications: List all prescriptions, over the counter, vitamins, and herbal supplements.

Drug	Dose	Times Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take NSAIDs? (Advil, Aleve, Ibuprofen, Motrin) () Yes () No How often? _____

Do you take Aspirin? () Yes () No How often? _____

Do you take blood thinners? () Yes () No Type and how often? _____

Medical History: (Please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pain/tightness | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes (Type _____) | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> TB(Tuberculosis) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Hepatitis (Type _____) | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> HIV/AIDS |

Surgeries: (List all surgeries you had and when)

Surgery	Year	Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: (Has any family member ever had any serious illnesses? ie, Cancer, Diabetes, Heart Disease)

Type	Family Member
_____	_____
_____	_____
_____	_____

Social History: (Do you do any of the following?)

Do you have any special dietary needs? Yes No

If yes please list: _____

Smoke Yes No How Much? _____ How Long? _____

Drink Alcohol Yes No How Much? _____ How Long? _____

Use Drugs Yes No How Much? _____ How Long? _____

Are you an organ donor? Yes No

Do you have an advance directive? Yes No

Do you feel safe in your home? Yes No

Do you have any mobility limitations? Yes No

Do you need an interpreter? Yes No If yes please list language: _____

Previous Testing? (Have you had any of the following?)

Recent Lab Work? Yes No When? _____ Where? _____

Recent x-rays? Yes No When? _____ Where? _____

Immunizations: Childhood immunizations current: Yes No Unknown

Source of information: Patient/Guardian Physician Immunization Record

Date of last tetanus: _____ Date of influenza-ask 10/1-2/28: _____

History Reviewed By: _____

Staff Reviewing Signature

Date