* PLEASE COMPLETE FRONT AND BACK

# HEALTH HISTORY

Date: _____
Patient #: _____

**WELCOME TO ACUTE SURGICAL CARE, LLC. AS A NEW PATIENT, PLEASE FILL OUT THE INFORMATION FOUND BELOW TO THE BEST OF YOUR ABILITY.**

Patient Name: _____ DOB: _____

**Chief Complaint:** _____

**History of Present Illness:**

**Location:** _____
(WHERE IS THE PAIN/PROBLEM?)

**Quality:** _____
(EXAMPLE: NORMAL VERSUS ABNORMAL COLOR, ACTIVITY, ETC.)

**Severity:** _____
(HOW SEVERE IS THE PAIN/PROBLEM ON A SCALE OF 1-10, WITH 10 BEING THE MOST SEVERE?)

**Duration:** _____
(HOW LONG HAVE YOU HAD THIS PAIN/PROBLEM? OR, WHEN DID IT START?)

**Timing:** _____
(DOES THE PAIN/PROBLEM OCCUR AT A SPECIFIC TIME)

**Context:** _____
(WHERE WERE YOU AT THE ONSET OF THIS PAIN/PROBLEM?)

**Associated Signs/Symptoms:** _____
(WHAT OTHER ASSOCIATED PROBLEMS ARE YOU HAVING?)

**Modifying Factors:** _____
(WHAT MAKES THE PAIN/PROBLEM WORSE OR BETTER? OR, HAVE YOU HAD PREVIOUS EPISODES?)

**Past Medical History:**

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Measles | no yes | Anemia | no yes | Back Trouble | no yes | Hepatitis | no yes |
| Mumps | no yes | Bladder Infections | no yes | High Blood Pressure | no yes | Ulcer | no yes |
| Chickenpox | no yes | Epilepsy | no yes | Low Blood Pressure | no yes | Kidney Disease | no yes |
| Whooping Cough | no yes | Migraine Headaches | no yes | Hemorrhoids | no yes | Thyroid Disease | no yes |
| Scarlet Fever | no yes | Tuberculosis | no yes | Date of last chest x-ray | _____ | Bleeding Tendency | no yes |
| Diphtheria | no yes | Diabetes | no yes | Asthma | no yes | Any other disease (please list): | |
| Small pox | no yes | Cancer | no yes | Hives or Eczema | no yes | | |
| Pneumonia | no yes | Polio | no yes | AIDS or HIV+ | no yes | | |
| Rheumatic Fever | no yes | Glaucoma | no yes | Infectious Mono | no yes | | |
| Heart Disease | no yes | Hernia | no yes | Bronchitis | no yes | | |
| Arthritis | no yes | Blood or Plasma | | Mitral Valve Prolapse | no yes | | |
| Venereal Disease | no yes | Transfusions | no yes | Stroke | no yes | | |

| **Previous Hospitilizations/Surgeries/Serious Illnesses** | **When?** | **Hospital, City, State** |
|---|---|---|
| | | |
| | | |
| | | |

**Medications:** (include nonprescriptions) _____

**Patient Social History:**

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol: Never: _____ Rarely: _____ Moderatly: _____ Daily: _____

Use of Tobacco: Never: _____ Previously, but quit: _____ Current Packs/Day: _____

Use of Drugs: Never: _____ Type/Frequency: _____

Excessive Exposure at home or at work to:

**Family Medical History**

| | AGE | DISEASES | IF DECEASED, CAUSE OF DEATH |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |

## Review of Symptoms: Please indicate any personal history below:

### □ Constitutional Symptoms
Good general health lately ..... no yes
Recent weight change ..... no yes
Fever ..... no yes
Fatigue ..... no yes
Headaches ..... no yes

### □ Eyes
Eye disease or injury ..... no yes
Wear glasses/contact lenses ..... no yes
Blurred or double vision ..... no yes

### □ Ears/Nose/Mouth/Throat
Hearing loss or ringing ..... no yes
Earaches or drainage ..... no yes
Chronic sinus problem or rhinitis ..... no yes
Nose Bleeds ..... no yes
Mouth sores ..... no yes
Bleeding gums ..... no yes
Bad breath or bad taste ..... no yes
Sore throat or voice change ..... no yes
Swollen glands in neck ..... no yes

### □ Cardiovascular
Heart trouble ..... no yes
Chest pain or angina pectoris ..... no yes
Palpitation ..... no yes
Shortness of breath w/ walking or lying flat ..... no yes
Swelling of feet, ankles or hands ..... no yes

### □ Respiratory
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ..... no yes
Spitting up blood ..... no yes
Shortness of breath ..... no yes
Wheezing ..... no yes

### □ Gastrointestinal
Loss of appetite ..... no yes
Change in bowel movements ..... no yes
Nausea or vomiting ..... no yes
Frequent diarrhea ..... no yes
Painful bowel movements or constipation ..... no yes
Rectal bleeding or blood in stool ..... no yes
Abdominal pain ..... no yes

### □ Genitourinary
Frequent urination ..... no yes
Burning or painful urination ..... no yes
Blood in urine ..... no yes
Change in force of strain when urinating ..... no yes
Incontinence or dribbling ..... no yes
Kidney stones ..... no yes
Sexual difficulty ..... no yes
Male - testicle pain ..... no yes
Female - pain with periods ..... no yes
Female - irregular periods ..... no yes
Female - vaginal discharge ..... no yes
Female - # of pregnancies ..... _____
Female - # of miscarriages ..... _____
Female - date of last pap smear ..... _____

### □ Musculoskeletal
Joint pain ..... no yes
Joint stiffness or swelling ..... no yes
Weakness of muscles or joints ..... no yes
Muscle pain or cramps ..... no yes
Back pain ..... no yes
Cold extremities ..... no yes
Difficulty in walking ..... no yes

### □ Integumentary (skin, breast)
Rash or itching ..... no yes
Change in skin color ..... no yes
Change in hair or nails ..... no yes
Varicose veins ..... no yes
Breast pain ..... no yes
Breast lump ..... no yes
Breast discharge ..... no yes

### □ Neurological
Frequent or recurring headaches ..... no yes
Light headed or dizzy ..... no yes
Convulsions or seizures ..... no yes
Numbness or tingling sensations ..... no yes
Tremors ..... no yes
Paralysis ..... no yes
Head injury ..... no yes

### □ Psychiatric
Memory loss or confusion ..... no yes
Nervousness ..... no yes
Depression ..... no yes
Insomnia ..... no yes

### □ Endocrine
Glandular or hormone problem ..... no yes
Excessive thirst or urination ..... no yes
Heat or cold intolerance ..... no yes
Skin becoming dryer ..... no yes
Change in hat or glove size ..... no yes

### □ Hematologic/Lymphatic
Slow to heal after cuts ..... no yes
Bleeding or bruising tendency ..... no yes
Anemia ..... no yes
Phlebitis ..... no yes
Past transfusion ..... no yes
Enlarged glands ..... no yes

### □ Allergic/Immunologic
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics ..... no yes
Morphine, Demerol or other narcotics ..... no yes
Novocain or other anesthetics ..... no yes
Aspirin or other pain remedies ..... no yes
Tetanus antitoxin or other serums ..... no yes
Iodine, Merthiolate or other antiseptic ..... no yes
Other drugs/medications: _____
_____
_____
_____
Known food allergies: _____
_____
_____
_____
_____
Environmental allergies: _____
_____
_____
_____
_____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

SIGNATURE OF DOCTOR _____ DATE _____