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UCLA Santa Monica General Surgery

INITIAL VISIT HEALTH HISTORY FORM

All information contained in this questionnaire is strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:		☐ M ☐ F	**DOB:**		**AGE:**	
Home address *(Street)*:			**Home phone:**			
(City/State/Zip):			**Mobile phone:**			
Email:			**Fax:**			

Referring MD:	**Primary/Other MD:**
Specialty:	Specialty:
Address:	Address:
Cite/State/Zip:	Cite/State/Zip:
Phone:	Phone:
Fax:	Fax:

Nearest Relative/Emergency Contact:

Relation to you:	Work phone:
Home phone:	Mobile phone:

MEDICAL HISTORY

Have you ever had any of the following conditions?

DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE
Angina				Stomach ulcer			
Heart attack				Liver disease/cirrhosis			
Heart failure				Kidney disease/dialysis			
Heart murmur				Kidney stones			
High blood pressure				Blood clots/DVT			
Diabetes				Excessive bleeding			
Stroke				Bone loss/osteoporosis			
Asthma				Bone fracture(specify)			
Emphysema				Cancer(specify)			

List any other medical problems that your doctors have diagnosed

Previous Surgery

Date		Type		Reason		Hospital	
Date		Type		Reason		Hospital	
Date		Type		Reason		Hospital	

List your prescribed drugs and over-the-counter drugs, including vitamins, supplements, and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications/foods	**Reaction You Had**

Social History/Lifestyle								
Occupation		☐ If retired, former occupation						
Who lives at home with you?								
What kind of regular exercise do you get?		How many flights of stairs can you climb before becoming tired or short of breath?	☐ None ☐ One ☐ Two ☐ More than two					
(Women) Are you pregnant? ☐ Yes ☐ No		(Women) Are you presently trying to conceive a child? ☐ Yes ☐ No						
Smoking	Pks/Day	Yrs smoked	Quit date	Alcohol	#Servings	☐ Monthly	☐ Weekly	☐ Daily

FAMILY HEALTH HISTORY

Do any of the following conditions run in your family?

- ☐ Thyroid disease (specify) ______________________
- ☐ High calcium
- ☐ High blood pressure
- ☐ Stomach ulcers
- ☐ Cancer (specify) ______________________
- ☐ Difficulty with anesthesia
- ☐ Excessive bleeding
- ☐ Others (list) ____

PLEASE DETAIL THESE AND ANY OTHER SIGNIFICANT FAMILY HEALTH PROBLEMS BELOW

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Other/specify	☐ M ☐ F	
	☐ M ☐ F		Other/specify	☐ M ☐ F	

REVIEW OF SYSTEMS

Please explain any yes answers in the space provided

Constitutional:				**Gastrointestinal:**			
Fever or chills	☐ Yes	☐ No		Abdominal pain	☐ Yes	☐ No	
Weight loss / gain (circle)	☐ Yes	☐ No		Nausea or vomiting	☐ Yes	☐ No	
Feeling hot / cold (circle)	☐ Yes	☐ No		Heartburn	☐ Yes	☐ No	
Excessive thirst	☐ Yes	☐ No		Constipation / diarrhea (circle)	☐ Yes	☐ No	
Fatigue or low energy level	☐ Yes	☐ No		Bloody or black stools	☐ Yes	☐ No	
Loss of appetite	☐ Yes	☐ No					
Eyes:				**Genitourinary:**			
Blurred vision	☐ Yes	☐ No		Frequent urination	☐ Yes	☐ No	
Double vision	☐ Yes	☐ No		Painful urination	☐ Yes	☐ No	
Dry/irritated eyes	☐ Yes	☐ No		Blood in urine	☐ Yes	☐ No	
Ear/Nose/Throat/Mouth:				**Neurological/Psychological:**			
Ear infection	☐ Yes	☐ No		Memory loss or forgetfulness	☐ Yes	☐ No	
Difficulty swallowing	☐ Yes	☐ No		Depression or depressed mood	☐ Yes	☐ No	
Change in voice	☐ Yes	☐ No		Difficulty sleeping	☐ Yes	☐ No	
Respiratory:				**Integumentary:**			
Wheezing	☐ Yes	☐ No		Dry skin	☐ Yes	☐ No	
Shortness of breath	☐ Yes	☐ No		Itching	☐ Yes	☐ No	
Cough	☐ Yes	☐ No		Abnormal hair loss / growth (circle)	☐ Yes	☐ No	
Cardiovascular:				**Hematologic/lymphatic:**			
Chest pain	☐ Yes	☐ No		Swollen glands (location)	☐ Yes	☐ No	
Palpitations	☐ Yes	☐ No		Leg swelling one / both (circle)	☐ Yes	☐ No	
Musculoskeletal:				**Allergic/Immunologic:**			
Bone / joint pain (circle)	☐ Yes	☐ No		Seasonal allergies	☐ Yes	☐ No	
Back pain	☐ Yes	☐ No		**Other (list):**			
Muscle pain	☐ Yes	☐ No			☐ Yes	☐ No	
Muscle weakness	☐ Yes	☐ No					

AUTHORIZATION: I AUTHORIZE TRANSFER OF MY MEDICAL RECORDS TO UCLA GENERAL SURGERY ASSOCIATES AND MY REFERRING PHYSICIANS (LISTED ON FRONT OF PAGE).

Print name:	Signed:	Date: