The Permanente Medical Group, Inc.

MR#: ______

Name: ______

IMPRINT AREA

# SURGICAL ADMISSIONS HISTORY QUESTIONNAIRE

Please complete this form as carefully as you can. It will be made part of your medical record and will, of course, be confidential.

DATE: ______ FULL NAME: ______
FIRST MIDDLE LAST

Medical Record Number: ______ Sex: ☐ M ☐ F Birth Date: ______ Age: ______

Your Address: ______
STREET CITY STATE ZIP CODE

Telephone: Work: ______ Home: ______

Occupation: ______ Employer: ______

Spouse's Name: ______ Work Telephone: ______

Person you wish us to contact, if not above: ______

Phone: ______

**CHIEF COMPLAINT:**

1. What is the chief reason that you are consulting the surgeon? ______
2. When did the problem first start? ______
3. If an injury, is it work related? ______

## PAST MEDICAL HISTORY

### CHILDHOOD

4. Did you have the usual childhood diseases, such as measles, mumps, chicken pox? ______
5. Did you have unusual childhood diseases, such as rheumatic fever, heart disease, leukemia, kidney disease, hormone disorder, tumors? Circle and explain. ______
6. Do you bleed excessively or easily, such as after tooth extractions or accidents? ☐ Yes ☐ No

   Have you ever required transfusion? ☐ Yes ☐ No

   If yes, when? ______ About how many? ______

## PAST MEDICAL HISTORY (continued)

### ADULT ILLNESSES

7. Please list medical diseases for which you are now being treated, or for which you have been admitted to the hospital:

| | DATE OF ONSET OR DURATION |
|---|---|
| ☐ High blood pressure | |
| ☐ Diabetes | |
| ☐ Heart attack | |
| ☐ Heart failure | |
| ☐ Stroke | |
| ☐ Vascular (blood vessel) Dis. | |
| ☐ Tuberculosis | |
| ☐ Hepatitis | |
| ☐ Other: Explain | |
| | |
| | |

8. **FEMALES**
   a. Pregnancies, how many? ______
   b. Deliveries, how many? ______
   c. Miscarriages or abortions ☐ Yes ☐ No How many? ______
   d. Caesarean Sections, how many? ______
   e. Complications of pregnancy? ______
   f. Could you be pregnant now? ☐ Yes ☐ No
   g. Date of last normal period? ______

9. **OPERATIONS** with dates, and hospital if known: ______

10. **MEDICATIONS**: Dose and how often taken: ______

ALLERGIES TO MEDICATIONS

## FAMILY HISTORY

| | | | LIVING | | AGE | CHIEF MEDICAL DISEASES |
|---|---|---|---|---|---|---|
| 11. | Parents: | Mother | ☐ Yes | ☐ No | ______ | ______ |
| | | Father | ☐ Yes | ☐ No | ______ | ______ |
| 12. | Siblings: | Brother | ☐ Yes | ☐ No | ______ | ______ |
| | | Brother | ☐ Yes | ☐ No | ______ | ______ |
| | | Brother | ☐ Yes | ☐ No | ______ | ______ |
| | | Sister | ☐ Yes | ☐ No | ______ | ______ |
| | | Sister | ☐ Yes | ☐ No | ______ | ______ |
| | | Sister | ☐ Yes | ☐ No | ______ | ______ |

13. Children

| | BIRTH WEIGHT | LIVING | | AGE | CHIEF MEDICAL DISEASES |
|---|---|---|---|---|---|
| Male | ______ | ☐ Yes | ☐ No | ______ | ______ |
| Male | ______ | ☐ Yes | ☐ No | ______ | ______ |
| Male | ______ | ☐ Yes | ☐ No | ______ | ______ |
| Female | ______ | ☐ Yes | ☐ No | ______ | ______ |
| Female | ______ | ☐ Yes | ☐ No | ______ | ______ |
| Female | ______ | ☐ Yes | ☐ No | ______ | ______ |

14. Circle disease(s) that tend to run in the family:
Diabetes, high blood pressure, heart attacks, strokes, cancer, bleeding disorders, tuberculosis, others:

______________________________

______________________________

______________________________

## SOCIAL HISTORY

15. Do you smoke? ☐ Yes ☐ No Cigarettes? ☐ Yes ☐ No Packs per day? ______ How long? ______

Cigar? ☐ Yes ☐ No Pipe? ☐ Yes ☐ No When will you quit? ______

Have your ever smoked? ______ How much? ______ When did you stop? ______

16. Do you drink alcohol? ☐ Yes ☐ No Type? ______

How much? ______ How often? ______

17. What type of work do you do, or have you done most of your life? ______

______________________________

18. Have you traveled out of the country? ☐ Yes ☐ No Where? ______

______________________________

When? ______

19. Are you single? ☐ Yes ☐ No Married? ☐ Yes ☐ No Divorced? ☐ Yes ☐ No

## REVIEW OF SYSTEMS

(If yes to following questions, when in recent past? How often?

| **CENTRAL NERVOUS SYSTEM** | **YES** | **NO** |
|---|---|---|
| 20. Do you have seizures? | ☐ | ☐ |
| Severe headaches? | ☐ | ☐ |
| 21. Temporary changes in vision or hearing? | ☐ | ☐ |
| 22. Any temporary loss of strength or sensation on one side? | ☐ | ☐ |

| **CARDIOVASCULAR** (Check or Explain) | | |
|---|---|---|
| 23. Do you have chest pain, chest tightness, or angina on exertion? | ☐ | ☐ |
| At rest? | ☐ | ☐ |
| Duration? ____________________ | | |
| 24. Chronic ankle swelling? | ☐ | ☐ |
| 25. Can you sleep flat in bed? | ☐ | ☐ |
| 26. Do you wake up at night short of breath? | ☐ | ☐ |
| 27. Do you have frequent dizzy or fainting spells? | ☐ | ☐ |

| **RESPIRATORY** | | |
|---|---|---|
| 28. Do you get short of breath on exertion? | ☐ | ☐ |
| 29. Can you walk two flights of stairs without significant discomfort? | ☐ | ☐ |
| 30. Do you have frequent yellow or green sputum? | ☐ | ☐ |
| 31. Has there been any change in your voice recently? | ☐ | ☐ |
| 32. Do you have frequent or chronic chest pain? | ☐ | ☐ |
| 33. Do you cough up blood? | ☐ | ☐ |
| 34. Have you ever had phlebitis, or blood clots in your legs? | ☐ | ☐ |

| **GASTROINTESTINAL** | | |
|---|---|---|
| 35. Have you lost or gained weight over the last several months? | ☐ | ☐ |
| How much? ____________________ | | |
| 36. Frequent nausea, vomiting, diarrhea, or constipation? ____________________ | | |
| 37. Change in bowel habits or stool size? | ☐ | ☐ |
| 38. Black tarry stools? | ☐ | ☐ |
| Blood in stools? | ☐ | ☐ |
| 39. Hemorrhoids (piles)? | ☐ | ☐ |
| Hernias? (ruptures) | ☐ | ☐ |
| 40. Peptic ulcer disease? | ☐ | ☐ |
| 41. Have your ever vomited blood? | ☐ | ☐ |

| **GENITOURINARY** | | |
|---|---|---|
| 42. Cloudy urine? | ☐ | ☐ |
| Blood in urine? | ☐ | ☐ |
| Burn on urination? | ☐ | ☐ |
| 43. History of stones? | ☐ | ☐ |
| Do you get up at night several times to urinate? | ☐ | ☐ |
| 44. For men, do you have difficulty initiating urination? | ☐ | ☐ |