FORT WORTH SURGICAL CONSULTANTS

Patient History Form

Date: _____

Patient name: _____ **Date of birth:** _____

Referred by: _____ **Primary Care Physician:** _____

New patient? ☐ Yes ☐ No **Post operative?** ☐ Yes ☐ No

Reason for visit: _____

List of current medications: _____

_____ ☐ List provided

Preferred pharmacy (include phone number, if possible): _____

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please list medications: _____

Do you any allergies to latex products? ☐ Yes ☐ No

Medical History: Please list all conditions/illnesses (ex. Diabetes, asthma, cancer, COPD, etc.)

_____

_____

Prior surgeries and approximate dates:

Surgery: _____ **Date:** _____

Surgery: _____ **Date:** _____

Surgery: _____ **Date:** _____

Surgery: _____ **Date:** _____

Do you or have you used any tobacco products? ☐ Yes ☐ No **If yes, please answer the following:**

Type of tobacco used: _____ **Amount and frequency:** _____ **Age started:** _____

Amount of years used: _____ **Have you quit?** ☐ Yes ☐ No **When?** _____

Do you drink alcohol? ☐ Yes ☐ No **Type:** _____ **Drinks per week:** _____

Do you drink caffeine? ☐ Yes ☐ No

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Please complete the following symptom questionnaire:

Symptom	Yes	No
Constitutional		
Fever	☐	☐
Fatigue	☐	☐
Weight loss	☐	☐
Head		
Vision changes	☐	☐
Hearing changes	☐	☐
Difficulty swallowing	☐	☐
Sore throat	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐
Cardiovascular		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Nausea/Vomiting	☐	☐
Blood in stool	☐	☐
Musculoskeletal		
Muscle weakness	☐	☐
Joint pain	☐	☐

Symptom	Yes	No
Neurological		
Headache	☐	☐
Seizures	☐	☐
Dizziness	☐	☐
Urinary		
Pain with urination	☐	☐
Blood in urine	☐	☐
Skin		
Rash	☐	☐
Itching	☐	☐
Skin lesions	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Metabolic		
Heat intolerance	☐	☐
Cold intolerance	☐	☐
Blood		
Easy bruising	☐	☐
Easy bleeding	☐	☐
Swollen lymph node	☐	☐

Family History: Please list conditions/illness (ex. Diabetes, high blood pressure, cancer, etc.)

Father: _____ Mother: _____

Sister: _____ Brother: _____

Grandparents/other: _____

Preventative Measures:

Have you had a colonoscopy? ☐ Yes ☐ No Date:

Have you had a mammogram? ☐ Yes ☐ No Date:

Have you had a pneumonia vaccine? ☐ Yes ☐ No Date:

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