Grand River Health
General Surgery New Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name: _____ **First Name:** _____ **MI:** _____

Today's Date: _____ **Doctor that referred you:** _____

Date of Birth: _____**Age:**____ **Local Pharmacy:** _____

Chief Complaint
What is the main reason for your visit today? (Describe your problem in detail)

_____

When did you first notice this problem? _____

Is this injury work related? Y N

Past Medical and Social History

List all serious illnesses in your immediate family. Please list family member.
(for example: mother-diabetes or brother-bladder cancer)

_____ _____ _____
_____ _____ _____

List any personal past illness and/or surgeries:

_____
_____
_____

Allergies and reaction:

_____
_____

List any medications you are taking and the dosage:

_____
_____
_____

Do you smoke? Y N Former Smoker? Y N Do you drink? Y N Socially

(MORE QUESTIONS ON OTHER SIDE)

Physician Use Only: (Comments/Notes)

Height:_____ **Weight:**_____ **B/P:** _____ **Temp:** _____ **Pulse/Resp:**_____ **O2:**_____

Patient Name: _____ **DOB:** _____

Review of Systems

Do you now or have you had any problems related to the following systems? **Circle YES or NO.**
Please explain any **YES** answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Feeling Poorly/Tired	Y	N
Recent Weight Loss/Gain lbs_____		

Cardiovascular

Slow Heart Rate	Y	N
Fast Heart Rate	Y	N
Chest Pain	Y	N
Palpitations	Y	N
Leg Claudication	Y	N
Lower Extremity Edema	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Post Nasal Drip	Y	N
Difficulty Breathing while Lying Down?	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Constipation	Y	N
Diarrhea	Y	N
Dark Tarry Stool	Y	N
Blood in Stool	Y	N
Hemorrhoids	Y	N
Rectal Trouble	Y	N
Stomach Ulcers	Y	N

Integumentary

Skin Lesions	Y	N
Skin Wounds	Y	N
Persistent Itch	Y	N
Change in Mole	Y	N
Breast Pain	Y	N
Breast Lump	Y	N
Cellulitis	Y	N

Psychiatric

Depression	Y	N
Anxiety	Y	N
Suicidal	Y	N
Change in Personality	Y	N
Emotional Problems	Y	N

Neurological

Fainting	Y	N
Dizziness	Y	N
Confusion	Y	N
Limb Weakness	Y	N
Difficulty Walking	Y	N
Convulsions	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Swollen Glands in Neck	Y	N
Easy Bleeding	Y	N
Easy Bruising	Y	N

Have you ever taken?

Insulin	Y	N
Cortisone	Y	N
Thyroid Medication	Y	N
Blood Pressure Meds	Y	N
Birth Control Pills	Y	N
Other _____		

Other medical history you want to share?

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____