

HealthQuest Surgical Associates

Name: _____

What is the reason for your appt. with us? _____

What test have you had for this problem? _____

Allergies To Medications:

Latex Allergies: Yes No **X-Ray Dye Allergies:** Yes No

Primary language other than English _____

Interpreter needed? Yes No

Primary Occupation _____

Hobbies _____

Height _____ Weight _____

MARITAL STATUS

Married Single Divorced Widowed NA

Spouse/SO name _____ NA

Children — Ages _____ NA

SOCIAL HISTORY

YES NO

Do you currently smoke?

Have you ever used tobacco products?

How many packs per day? _____ How many years? _____

Do you use alcohol?

Amount per week _____

Have you ever been treated for drug/alcohol problems?

Do you drink caffeinated beverages? (coffee, tea, pop)

How many per day? _____

Dietary restrictions?

MEDICAL HISTORY / MEDICAL PROBLEMS

LIST ANY SURGERIES

REVIEW OF GENERAL SYSTEMS

Have you ever been diagnosed as having the following illnesses, or as having any of the following symptoms. If yes, state year.

Unusual fatigue Yes Year _____ No

Unexplained change in weight Yes Year _____ No

Recurrent fevers, chills, sweats Yes Year _____ No

Increased thirst Yes Year _____ No

Intolerance of heat or cold Yes Year _____ No

Decreased appetite Yes Year _____ No

Excessive thirst or appetite Yes Year _____ No

Cancer Yes Year _____ No

EYES

Vision changes Yes Year _____ No

Pain/Itching/Drainage Yes Year _____ No

Glaucoma Yes Year _____ No

Name: _____

DOB _____

HQSA MD _____

Date of Service: _____

PCP: _____

FOR OFFICE USE ONLY

EARS, NOSE & THROAT

Sinus congestion Yes Year _____ No

Sneezing Yes Year _____ No

Hearing problems Yes Year _____ No

Difficulty swallowing Yes Year _____ No

Persistent sore throats Yes Year _____ No

CARDIOVASCULAR

High blood pressure Yes Year _____ No

Low blood pressure Yes Year _____ No

Heart attack Yes Year _____ No

Chest pain Yes Year _____ No

Racing heart Yes Year _____ No

Shortness of breath at night Yes Year _____ No

Swollen feet Yes Year _____ No

Heart murmur Yes Year _____ No

Leg cramps while walking Yes Year _____ No

High cholesterol Yes Year _____ No

Anemia Yes Year _____ No

Rheumatic fever Yes Year _____ No

Sickle cell anemia Yes Year _____ No

Blood transfusions & year Yes Year _____ No

Any heart disease Yes Year _____ No

RESPIRATORY

Shortness of breath Yes Year _____ No

Cough Yes Year _____ No

Coughing up phlegm/blood Yes Year _____ No

Frequent chest colds Yes Year _____ No

Wheezing, difficulty breathing Yes Year _____ No

Asthma/Bronchitis/Emphysema Yes Year _____ No

GASTROINTESTINAL

Difficulty swallowing Yes Year _____ No

Heartburn Yes Year _____ No

Bloating Yes Year _____ No

Abdominal pain Yes Year _____ No

Nausea/Vomiting Yes Year _____ No

Ulcer Yes Year _____ No

Hernia Yes Year _____ No

Diarrhea Yes Year _____ No

Constipation Yes Year _____ No

Laxative use Yes Year _____ No

Black/Bloody stools Yes Year _____ No

Liver disease/Hepatitis Yes Year _____ No

Weight loss Yes Year _____ No

INTEGUMENTARY

Rash Yes Year _____ No

Itching Yes Year _____ No

