IDAHO SURGICAL

Health History Questionnaire

Patient Name: _____ Date: _____

Primary Care Physician: _____Date of Birth: _____

How did you hear about our clinic? _____

Preferred pharmacy and location: _____

Current medications, please include any vitamins or over the counter medications that you are taking:

_____

_____

_____

Do you take any blood thinners? _____

Allergies:_____

Do you use tobacco/vape? _____

Do you do any recreational drugs? _____

Do you drink alcohol? _____

Please list ALL past surgeries that you have had and the dates:_____

_____

_____

Family History:

Age of Mother: _____, Deceased age: _____ Age of Father: _____, Deceased age: _____

Pertinent health problems: _____

Family history of Cancer: _____Number of Brothers: _____ Number of Sisters: _____

Pertinent health problems: _____

Past Medical History:

Do you have any heart disease? _____ Do you have a cardiologist, if so who? _____

Heart Attack date/treatment: _____CABG: _____ Stent: _____

Coronary artery disease: _____ Congestive heart failure: _____Irregular heart rhythm/Afib: _____

Valve disorder: _____ Pacemaker: _____ Defibrillator: _____Peripheral vascular disease: _____

High blood pressure: _____ High Cholesterol: _____ Diabetes: _____HbA1c_____ Date: _____

Thyroid disease: _____ COPD/Emphysema_____ Sleep apnea _____ Kidney disease _____

Liver disease _____ Hematology _____ Blood clotting disorder _____ Depression/anxiety _____

Infectious disease: TB _____ HIV/AIDS _____ STDs _____ Hepatitis _____ Drug resistant infections _____