Holland Hospital

GENERAL SURGERY

Medical History Questionnaire

Patient: _____ Date of Birth.:_____ Age: _____

Occupation: _____ Height: _____ Weight: _____

Marital status: _____ Number of children: _____

Pharmacy and location used: _____

Medication allergies: _____
_____
_____
_____

Latex allergy: ☐ No ☐ Yes

List past surgical procedures and year
(ex.: Appendectomy 1975):

_____
_____
_____
_____
_____
_____

Medication name: Ex: Lasix	Directions: 1 twice daily	Dose: 40 mg
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use Aspirin regularly? ☐ No ☐ Yes
What mg? _____

Answer yes or no:

Are you a current smoker?	☐ No	☐ Yes
If yes, how many years have you smoked? _____		
How many packs/day? _____		
Are you a former smoker?	☐ No	☐ Yes
Do you have smoking exposure?	☐ No	☐ Yes
Do you use recreational drugs?	☐ No	☐ Yes
If yes, how much? _____		
Do you use alcohol?	☐ No	☐ Yes
If yes, how much? _____		
Do you use caffeine (coffee, tea, pop):	☐ No	☐ Yes
If yes, how much? _____		

High blood pressure	☐ No	☐ Yes
Heart disease:		
Angina	☐ No	☐ Yes
Heart attack	☐ No	☐ Yes
Irregular heartbeat	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes
Rheumatic disease	☐ No	☐ Yes
Diabetes:	☐ No	☐ Yes
Lung disease:		
Asthma	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes
Recent bronchitis	☐ No	☐ Yes
Bleeding/clotting disorder	☐ No	☐ Yes
Psychiatric:		
Depression	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes
Nervous system:		
Stroke	☐ No	☐ Yes
Seizure	☐ No	☐ Yes
Gastrointestinal disease:		
Stomach ulcer	☐ No	☐ Yes
Hiatal hernia	☐ No	☐ Yes
Gallstones	☐ No	☐ Yes
Colitis	☐ No	☐ Yes
Diverticulitis	☐ No	☐ Yes
Kidney disease:		
Infections	☐ No	☐ Yes
Stones	☐ No	☐ Yes
Cancer:	☐ No	☐ Yes
What type? _____		
Thyroid problems:	☐ No	☐ Yes
MRSA:	☐ No	☐ Yes

Other medical problems (please list):

_____
_____
_____

PLEASE COMPLETE BACK OF FORM

Holland Hospital

GENERAL SURGERY

FAMILY HISTORY

Please check if any of your family members have the following:

			Which family members?
Heart disease?	☐ No	☐ Yes	
Diabetes?	☐ No	☐ Yes	
Colon cancer?	☐ No	☐ Yes	
Colon polyps?	☐ No	☐ Yes	
Thyroid disease?	☐ No	☐ Yes	
Bleeding disorder:			
Anemia?	☐ No	☐ Yes	
Clotting disorder?	☐ No	☐ Yes	
Breast cancer?	☐ No	☐ Yes	
Other cancer and what type?	☐ No	☐ Yes	

Father:

Age, if living: _____

Age when deceased: _____

Cause of death: _____

Mother:

Age, if living: _____

Age when deceased: _____

Cause of death: _____

Siblings:

How many brothers: _____

Age when deceased: _____

Cause of death: _____

How many sisters: _____

Age when deceased: _____

Cause of death: _____