Nebraska
Surgical Specialists
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CONFIDENTIAL PATIENT HISTORY FORM

Date: _____

Patient Name: _____

Who is your usual doctor? _____

CHIEF COMPLAINT: Why are you here to see the doctor today? _____

PLEASE DESCRIBE YOUR SYMPTOMS (if applicable):

Location: _____ (Where is the problem?) **Severity**: _____ (Scale of 1-10 (Best to Worst)) **Timing**: _____ (When / How often?)

Quality: _____ (Sharp/Stabbing/Dull/Achy/Constant/Intermittent) **Duration**: _____ (How long have you had this?) **Context**: _____ (Activity when it occurs?)

Modifiers: _____ (Anything that makes it better or worse?) **Associated signs or symptoms**: _____ (Anything related to this problem?)

PLEASE LIST THE SURGERIES THAT YOU HAVE HAD:

Surgery	Year	Hospital/City	Name of Surgeon

ANESTHESIA HISTORY:

Have you or any members of your family ever had problems with anesthesia? ☐Yes ☐No
If yes, who and what kind of problem? _____

ALLERGIES:

☐ I have no known allergies to drugs / medications.
Are you **sensitive/allergic** to **LATEX**?☐Yes ☐No **BANANAS** ☐Yes ☐No **SHELLFISH** ☐Yes ☐No **IODINE** ☐Yes ☐No
Please list any known allergies:

Allergy	Type of Reaction	Severity (Very Mild, Mild, Moderate, Severe)

MEDICATIONS:

Do you take any **MEDICATIONS**? ☐Yes ☐No
If you answered yes, please list your medications on the sheet provided.
Have you taken steroids this year? ☐Yes ☐No If yes, when and what kind? _____

FAMILY & SOCIAL HISTORY:

Is there a history of any of these diseases in your family?

Name of Illness	Family Member(s)	Name of Illness	Family Member(s)
☐Stroke		☐Crohn's disease	
☐Heart attack		☐Ulcerative colitis	
☐Sudden death		☐Breast cancer	
☐Tuberculosis		☐Ovarian cancer	
☐Peptic ulcer		☐Other:	
☐Colon cancer		☐Other:	

Patient Name:_____

FAMILY & SOCIAL HISTORY continued:

Do you smoke? ☐Yes ☐No If yes, packs per day: _____ and for how long: _____

If you have quit smoking, when did you quit? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much and how often do you drink?_____

What kind of work do you do?_____

ADVANCED DIRECTIVES:

Do you have a living will? ☐Yes ☐No

Do you have a Power of Attorney for Healthcare? ☐Yes ☐No

If you answered yes we recommend you bring copies for any procedure or admission

REVIEW OF SYSTEMS: Please check all that apply and explain below,

CONSTITUTIONAL		DESCRIBE:
Recent weight change	☐ Yes ☐ No ☐ Past ☐ Current	
Fever	☐ Yes ☐ No ☐ Past ☐ Current	
Fatigue	☐ Yes ☐ No ☐ Past ☐ Current	
EYES		
Blurred / Double vision	☐ Yes ☐ No ☐ Past ☐ Current	
Poor vision / Glasses/Contacts	☐ Yes ☐ No ☐ Past ☐ Current	
History of eye disease	☐ Yes ☐ No ☐ Past ☐ Current	
EARS/NOSE/MOUTH/THROAT		
Ringing in ears	☐ Yes ☐ No ☐ Past ☐ Current	
Deafness / Hearing aids	☐ Yes ☐ No ☐ Past ☐ Current	
Sore Throat / Runny nose	☐ Yes ☐ No ☐ Past ☐ Current	
Difficulty swallowing	☐ Yes ☐ No ☐ Past ☐ Current	
CARDIOVASCULAR		
Stroke / TIA	☐ Yes ☐ No ☐ Past ☐ Current	
Congestive Heart Failure (CHF)	☐ Yes ☐ No ☐ Past ☐ Current	
Angina / Chest pain	☐ Yes ☐ No ☐ Past ☐ Current	
Atrial fibrillation / Irregular heartbeat	☐ Yes ☐ No ☐ Past ☐ Current	
Hypertension	☐ Yes ☐ No ☐ Past ☐ Current	
Phlebitis / Clots	☐ Yes ☐ No ☐ Past ☐ Current	
Home oxygen	☐ Yes ☐ No ☐ Past ☐ Current	
Pacemaker / Defibrillator	☐ Yes ☐ No ☐ Past ☐ Current	
Swelling of the ankles / legs	☐ Yes ☐ No ☐ Past ☐ Current	
Varicose veins	☐ Yes ☐ No ☐ Past ☐ Current	
History of Rheumatic Fever	☐ Yes ☐ No ☐ Past ☐ Current	
RESPIRATORY		
Sleep apnea / CPAP	☐ Yes ☐ No ☐ Past ☐ Current	
Difficulty breathing / Shortness of breath	☐ Yes ☐ No ☐ Past ☐ Current	
Cough (productive?)	☐ Yes ☐ No ☐ Past ☐ Current	
Asthma / Hay fever	☐ Yes ☐ No ☐ Past ☐ Current	
Emphysema	☐ Yes ☐ No ☐ Past ☐ Current	
Bronchitis	☐ Yes ☐ No ☐ Past ☐ Current	
Tuberculosis (TB)	☐ Yes ☐ No ☐ Past ☐ Current	
GASTROINTESTINAL		
Heartburn / Acid reflux / GERD	☐ Yes ☐ No ☐ Past ☐ Current	
Nausea	☐ Yes ☐ No ☐ Past ☐ Current	
Vomiting	☐ Yes ☐ No ☐ Past ☐ Current	
Constipation	☐ Yes ☐ No ☐ Past ☐ Current	
Diarrhea	☐ Yes ☐ No ☐ Past ☐ Current	
Black stools	☐ Yes ☐ No ☐ Past ☐ Current	
Blood in stools	☐ Yes ☐ No ☐ Past ☐ Current	
Hemorrhoids	☐ Yes ☐ No ☐ Past ☐ Current	
Abdominal pain	☐ Yes ☐ No ☐ Past ☐ Current	
Crohn's / Ulcerative colitis	☐ Yes ☐ No ☐ Past ☐ Current	
Colonoscopy	☐ Never Last Date:	Findings:
GENITOURINARY		
Kidney problems	☐ Yes ☐ No ☐ Past ☐ Current	
Dialysis	☐ Yes ☐ No ☐ Past ☐ Current	
Frequent or burning urination	☐ Yes ☐ No ☐ Past ☐ Current	
Blood in urine	☐ Yes ☐ No ☐ Past ☐ Current	
Difficulty urinating	☐ Yes ☐ No ☐ Past ☐ Current	
Urinary incontinence	☐ Yes ☐ No ☐ Past ☐ Current	

Patient Name:_____

MUSCULOSKELETAL		
Leg pain (at rest or walking)	☐ Yes ☐ No ☐ Past ☐ Current	
Back pain	☐ Yes ☐ No ☐ Past ☐ Current	
Osteoarthritis	☐ Yes ☐ No ☐ Past ☐ Current	
Deformities	☐ Yes ☐ No ☐ Past ☐ Current	
Amputations	☐ Yes ☐ No ☐ Past ☐ Current	
Metal implants in your body	☐ Yes ☐ No ☐ Past ☐ Current	
SKIN		
Rash	☐ Yes ☐ No ☐ Past ☐ Current	
Skin cancer (basal, squamous, melanoma)	☐ Yes ☐ No ☐ Past ☐ Current	
Slow to heal	☐ Yes ☐ No ☐ Past ☐ Current	
Bleeding / bruising tendency	☐ Yes ☐ No ☐ Past ☐ Current	
NEUROLOGICAL		
Spinal cord injury	☐ Yes ☐ No ☐ Past ☐ Current	
Seizures	☐ Yes ☐ No ☐ Past ☐ Current	
Tremors	☐ Yes ☐ No ☐ Past ☐ Current	
Numbness (neuropathy)	☐ Yes ☐ No ☐ Past ☐ Current	
PSYCHIATRIC		
Depression / Anxiety	☐ Yes ☐ No ☐ Past ☐ Current	
Change in memory	☐ Yes ☐ No ☐ Past ☐ Current	
Insomnia	☐ Yes ☐ No ☐ Past ☐ Current	
ENDOCRINE		
Diabetes	☐ Yes ☐ No ☐ Past ☐ Current	
Thyroid	☐ Yes ☐ No ☐ Past ☐ Current	
Heat / Cold intolerance	☐ Yes ☐ No ☐ Past ☐ Current	
Hair loss	☐ Yes ☐ No ☐ Past ☐ Current	
Excessive thirst / urination	☐ Yes ☐ No ☐ Past ☐ Current	
HEMATOLOGIC / ONCOLOGIC		
Anemia	☐ Yes ☐ No ☐ Past ☐ Current	
Blood disorder	☐ Yes ☐ No ☐ Past ☐ Current	
History of blood transfusion	☐ Yes ☐ No ☐ Past ☐ Current	
Cancer	☐ Yes ☐ No ☐ Past ☐ Current	
Chemotherapy	☐ Yes ☐ No ☐ Past ☐ Current	
Radiation therapy	☐ Yes ☐ No ☐ Past ☐ Current	
ALLERGIC / IMMUNOLOGIC		
Rheumatoid arthritis	☐ Yes ☐ No ☐ Past ☐ Current	
Lupus	☐ Yes ☐ No ☐ Past ☐ Current	
Scleroderma	☐ Yes ☐ No ☐ Past ☐ Current	
Vasculitis	☐ Yes ☐ No ☐ Past ☐ Current	
Lactose intolerance	☐ Yes ☐ No ☐ Past ☐ Current	
Sprue / Gluten sensitivity	☐ Yes ☐ No ☐ Past ☐ Current	
INFECTIOUS		
Hepatitis A, B, C	☐ Yes ☐ No ☐ Past ☐ Current	
AIDS / HIV	☐ Yes ☐ No ☐ Past ☐ Current	
MEDICAL PROBLEMS NOT LISTED ABOVE:		

VITAL SIGNS:

Height: _____Weight: _____

ATTESTATION:

The above information that I have supplied is complete and accurate to the best of my knowledge.

_____ _____

Patient Signature Date

Reviewed by: _____Date: _____

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MEDICATIONS

Date: ______________________

Name: ____D.O.B.______________

Preferred Pharmacy: ____

***Do you take Aspirin?** ☐ Yes ☐ No ***Do you take Coumadin?** ☐ Yes ☐ No

Today's Date	Name of Medication	Dose	How often do you take it and when?	Why do you take it?