General Surgery Medical History

Ihor N. Ponomarenko, MD, FACS
Leland J. Soto III, MD, FACS

DATE_____

LAST NAME_____ **FIRST**_____ **AGE**_____

REASON FOR APPOINTMENT_____**DO YOU HAVE PAIN?** ____ where _____ how long_____

PATIENT CARE TEAM: What providers do you see? **Referred by**: _____

Primary Care: _____ **Cardiologist:** _____ **Urologist:** _____

Gastroenterologist: _____ **Endocrinologist:** _____ **OB/GYN:** _____

Other: _____

ALLERGIES: _____ **ARE YOU ON BLOOD THINNERS:** **YES** ☐ **NO** ☐

MEDICATIONS (Please list): _____

_____

Diseases / medical problems:							
	YES	**NO**	**NOTES**		**YES**	**NO**	**NOTES**
DO YOU HAVE A PACEMAKER?				Heart Burn/GERD			
Acid Reflux				Heart Attack			
Alcoholism				Heart Problems (other)			
Anemia/bleeding/bruising				Hemorrhoids			
Anxiety Disorder				Hernia			
Arthritis				High Blood Pressure			
Asthma				High Cholesterol			
Any blood relative who had anesthesia complications				Infection			
Complications related to anesthesia				Kidney disease/stones			
Bleeding tendencies/Disease				Liver Disease/Hepatitis			
Blood transfusion				Lumps, bumps, cysts, tumors			
Cancer				MRSA Infection			
Chest pain				**OTHER**			
Colitis				Pain while walking			
COPD/Emphysema				Seizures			
Depression				Shortness of Breath			
Diabetes				Skin disease			
Diverticulitis				Sleep apnea			
Enlarged Lymph Nodes				Stroke			
Gallstones				Substance Abuse			
Headaches/Migraine Headaches				Thyroid Disease/Problems			

SURGICAL HISTORY: *(Please List)* _____

_____

_____

Have you had a mammogram? where _____ when _____

Have you had a colonoscopy? where _____ when _____

FAMILY HISTORY: Please list disease (if known) I do not know my family history ☐

Mother _____ **Father** _____**Grandmother(M)**_____

Grandmother(F)_____ **Grandfather(M)**_____ **Grandfather(F)** _____

Sister(s) _____ **Brother(s)**_____

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FAMILY CANCER HISTORY:

			LIST FAMILY MEMBER & AGE DIAGNOSED
☐	☐	Breast Cancer under the age of 50	
☐	☐	Ovarian Cancer at any age	
☐	☐	Male breast cancer at any age	
☐	☐	3 or more family members with breast, pancreatic or prostate cancers at any age (on the same side)	
☐	☐	Triple negative (ER-, PR-, HER2Neu-) breast cancer	
☐	☐	2 Breast cancers in one person (same or different breast)	
☐	☐	Colon cancer under the age of 50	
☐	☐	Uterine/endometrial cancer at or under age 50	
☐	☐	3 or more of the following cancers at any age: colon, rectal, uterine/endometrial, brain, gastric/stomach, renal, kidney, pelvis, ureter, sebaceous adenoma	

FOR OFFICE USE ONLY:
Patient meets criteria for TeleGenetics ○ Y ○ N **Patient saw video/spoke to GC? ○ Y ○ N** **If test recommended, patient ○ Accepted myRisk/○ Decline**

SOCIAL HISTORY (PLEASE CIRCLE AND SPECIFY)

ADVANCE DIRECTIVE (PLEASE CIRCLE)	Select:	
CHILDREN	**Yes ☐ No ☐ How Many?**	**Male(s) Female(s)**
TOBACCO USE How many packs per day?	**Never ○ Daily ○ Weekly ○ Less ○ Former/Year Quit?**	**Chewing ○ Cigar ○ Dip ○ E-Cig ○ Hookah ○**
	Have you ever been offered smoking cessation? Yes ☐ No ☐	**Pipe ○ Snuff ○ Cigarette ○**
ALCOHOL INTAKE	Select: **Years of Use?**	**Beer ○ Wine ○ Liquor ○ Other ○**
DRUG/SUBSTANCE	Select: **Year Quit?**	**Pills ○ Marijuana ○ Cocaine ○ Heroin ○ Other ○**
GENERAL STRESS	**Low ○ Medium ○ High ○**	
DIET	Other	
EXERCISE ACTIVITY	Select **#_____ Days per week**	
CAFFEINE USE	Select **Year Quit? _____** Select	
Are you sexually active	**Yes ☐ No ☐ Do you practice Safe sex? ☐ Yes ☐ No ☐ Sometimes**	
GENDER IDENTITY	Select	
SEXUAL ORIENTATION	Select	
DO you have any concerns with meeting any of the following? (If so, please circle all that apply)	**○ Food ○ Housing ○ Transportation ○ Childcare ○ Heating ○ Other**	
Do you feel safe at home?	**☐ Yes ☐ No SPECIFY:**	

PATIENT SIGNATURE _____ PROVIDER SIGNATURE _____

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