



# GENERAL SURGERY HEALTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Name of Referring Doctor \_\_\_\_\_ Name of Primary Care Provider \_\_\_\_\_

Patient Email Address \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

Preferred Lab \_\_\_\_\_ Preferred Imaging Center \_\_\_\_\_

CHIEF COMPLAINT(S) AND DATE SYMPTOMS STARTED \_\_\_\_\_

IF INJURY, HOW DID INJURY OCCUR? \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

LIST ANY PAST SURGERIES	DATE	LIST CURRENT MEDICATIONS / DOSAGES	TIMES PER DAY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DO YOU SMOKE?  Yes AMOUNT \_\_\_\_\_  No FORMER SMOKER?  Yes  No HOW LONG DID YOU SMOKE? \_\_\_\_\_

DO YOU CONSUME ALCOHOL?  Yes  No AMOUNT \_\_\_\_\_

HAVE YOU EVER HAD A BLOOD TRANSFUSION?  Yes  No

### CHECK ANY PAST ILLNESSES

- Cancer
- Asthma
- Hypertension
- Heart Disease
- Diabetes
- Bronchitis
- Rheumatic Fever
- Kidney Problems
- Stroke
- Hepatitis
- Tuberculosis
- Drug Problem
- Epilepsy
- Pancreatitis
- Thyroid Problem
- Clotting Problems
- Liver Problems

Do you have religious beliefs that influence your medical decisions?  Yes  No

Do you have someone who loves and cares for you?  Yes  No  Not Sure

Do you have a source of joy in your life?  Yes  No  Not Sure

Do you have a sense of peace today?  Yes  No  Not Sure

If you answered "No" to any questions 1-3 above, would you like to be contacted by a team member of our Spiritual Wellness Team?  Yes  No

LIST ANY OTHER MEDICAL PROBLEMS \_\_\_\_\_

LIST ANY ALLERGIES \_\_\_\_\_

# GENERAL SURGERY HEALTH QUESTIONNAIRE

## FAMILY HEALTH HISTORY

### MOTHER

- |                                              |                                           |                                        |
|----------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> COPD             | <input type="checkbox"/> Obesity       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression       | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Thyroid Disorder |                                        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |                                        |

### FATHER

- |                                              |                                           |                                        |
|----------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> COPD             | <input type="checkbox"/> Obesity       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression       | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Thyroid Disorder |                                        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |                                        |

### GRANDMOTHER (Please indicate Maternal or Paternal)

- |                                              |                                           |                                        |
|----------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> COPD             | <input type="checkbox"/> Obesity       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression       | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Thyroid Disorder |                                        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |                                        |

### GRANDFATHER (Please indicate Maternal or Paternal)

- |                                              |                                           |                                        |
|----------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> COPD             | <input type="checkbox"/> Obesity       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression       | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Thyroid Disorder |                                        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |                                        |

### SISTER

- |                                              |                                           |                                        |
|----------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> COPD             | <input type="checkbox"/> Obesity       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression       | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Thyroid Disorder |                                        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |                                        |

### BROTHER

- |                                              |                                           |                                        |
|----------------------------------------------|-------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> COPD             | <input type="checkbox"/> Obesity       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression       | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Thyroid Disorder |                                        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |                                        |