HEALTH HISTORY
Barrington Surgeons, Ltd.

Welcome to our practice. Please fill out the information found below to the best of your ability.

Patient Name: _____ **Date of Birth:** _____

History of Present Illness:

Location: _____ Duration: _____
(Where is the problem?) (How long have you had this pain/problem?)

Severity: _____
(How severe is the pain on a scale of 1-5

Past Medical History:
Have you ever had the following: Circle "no" or "yes", leave blank if uncertain

Heart disease……	no	yes	Pneumonia……	no	yes	Bleeding tendency.	no	yes
Anemia……	no	yes	Rheumatic fever……	no	yes	Heartburn/reflux…	no	yes
Migraine headaches……	no	yes	Epilepsy……	no	yes	Stroke……	no	yes
Diabetes……	no	yes	Tuberculosis……	no	yes	Measles……..	no	yes
Blood/Plasma transfusions…	no	yes	Cancer……..	no	yes	Mumps……	no	yes
Asthma……	no	yes	Glaucoma……	no	yes	Chickenpox……	no	yes
Hives or eczema……	no	yes	Mitral valve prolapse……	no	yes	Whooping cough..	no	yes
Bronchitis……	no	yes	Ulcer……..	no	yes	Scarlet fever……	no	yes
Hepatitis……	no	yes	Thyroid disease……	no	yes	Arthritis……	no	yes
High blood pressure……	no	yes	HIV/Aids……	no	yes	Infectious disease..	no	yes

Previous Hospitalizations/Surgeries/Serious Illnesses **When?** **Hospital, City, State**

_____

_____

_____

List All Medications You are Currently Taking (including over the counter/herbals) _____

_____

_____

List Any ALLERGIES to Medications, Foods, Anesthetics or Environmental: _____

_____

Patient Social History:

Marital Status Single_____ Married _____ Separated _____ Divorced _____ Widowed _____
Use of Alcohol Never _____ Rarely _____ Moderate _____ Daily _____
Use of Tobacco Never _____ Previously, but quit: _____ Current packs/day _____
Use of Drugs Never _____ Type/Frequency _____
Use of Caffeine Never _____ Occasionally _____
Excessive exposure at home or work to: Fumes _____ Dust _____ Solvents _____ Airb-borne particles _____ Noise: _____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good general health lately	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Headaches	no	yes

Eyes

Eye disease or injury	no	yes
Wear glasses/contacts	no	yes
Blurred or double vision	no	yes

Cardiovascular

Heart trouble	no	yes
Chest pain or angina pectoris	no	yes
Shortness of breath w/walking or lying flat	no	yes
Swelling of feet, ankles, or hands	no	yes

Musculoskeletal

Joint stiffness or swelling	no	yes
Weakness of muscles or joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Difficulty walking	no	yes

Genitourinary

Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force or strain when urinating	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Male-testicle pain	no	yes
Female-pain w/periods	no	yes
Female-irregular periods	no	yes
Female-vaginal discharge	no	yes
Female-# of pregnancies	_____	
Female-# of miscarriages	_____	
Female-date of last pap smear	_____	

Endocrine

Glandular or hormone problem	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Skin becoming dryer	no	yes
Change in hat or glove size	no	yes

Respiratory

Chronic or frequent cough	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Wheezing	no	yes

Gastrointestinal

Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Painful bowel movements/constipation	no	yes
Frequent diarrhea	no	yes
Abdominal Pain	no	yes
Rectal bleeding or blood in stool	no	yes

Neurological

Lightheaded or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling sensation	no	yes
Tremors	no	yes
Head injury	no	yes
Frequent or recurring headaches	no	yes

Psychiatric

Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Insomnia	no	yes

Integumentary (skin, breast)

Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes

Hematologic/Lymphatic

Slow to heal after cuts	no	yes
Bleeding or bruising tendency	no	yes
Anemia	no	yes
Phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian	Date	Signature of Physician	Date
Signature of Patient, Parent or Guardian	Date	Signature of Physician	Date
Signature of Patient, Parent or Guardian	Date	Signature of Physician	Date