

**COASTAL SURGICAL GROUP
HEALTH HISTORY**

Thank you for selecting our healthcare team? We strive to provide you with the best possible care. To help us meet all your healthcare needs, please fill out the form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help you. (This information will be kept confidential.)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS: Check (√) symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	WOMEN only
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Numbness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Sweats	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Breast lump
MUSCLE/JOINT/BONE	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Extreme menstrual periods
<input type="checkbox"/> Arms <input type="checkbox"/> Hips	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Back <input type="checkbox"/> Legs	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision – Flashes	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Feet <input type="checkbox"/> Neck	CARDIOVASCULAR	<input type="checkbox"/> Vision – Halos	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<input type="checkbox"/> Chest pain	SKIN	<input type="checkbox"/> Vaginal discharge
GENITO-URINARY	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Other
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Hives	Date of last menstrual period _____
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Itching	Date of last Pap Smear _____
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Change in moles	Have you had a mammogram? _____
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Rash	Are you pregnant? _____
	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Scars	Number of children _____
	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Sore that won't heal	

CONDITIONS: Check (√) symptoms you currently have or have had in the past year.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease

MEDICATIONS List medications you are currently taking

ALLERGIES To medications or substances

_____	_____
_____	_____
_____	_____

