NORTH DALLAS SURGICAL SPECIALISTS
· 3600 SHIRE BLVD., SUITE 104 · RICHARDSON, TEXAS 75082 ·

MEDICAL HISTORY

Today's Date: _____/_____/_____

Name: _____

Birthdate: ___/___/___ Age: _____ Sex: _____

Occupation: _____

What is your approximate height? _____

Weight? _____

Reason for seeing the doctor today:

_____

_____

_____

What medical tests were completed prior to your visit today?

_____

_____

_____

List major illnesses or medical problems:

_____

_____

_____

List all operations (type and date):

_____

_____

_____

_____

Have you had a colonoscopy? ❑ Yes ❑ No What year? _____

List all medications you are allergic to and the reaction you have:

❑ Shellfish ❑ Iodine ❑ Latex/Surgical Glue ❑ Anesthesia

❑ Other: _____

PERSONAL HISTORY

Check any of the following you have had and when:

	No	Yes	Date
Pulmonary embolism	❑	❑	_____
Blood clots/DVT	❑	❑	_____
Rheumatic Fever	❑	❑	_____
Thyroid Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____
Circulatory Problems	❑	❑	_____
Heart Disease	❑	❑	_____
Heart Murmur	❑	❑	_____
Hepatitis	❑	❑	_____
Chemotherapy	❑	❑	_____
Excess Bleeding	❑	❑	_____
Diverticulosis	❑	❑	_____
Pancreatitis	❑	❑	_____
Tuberculosis	❑	❑	_____
Emphysema	❑	❑	_____
Jaundice	❑	❑	_____
Arthritis	❑	❑	_____
Cirrhosis	❑	❑	_____
Cancer	❑	❑	_____
Colitis	❑	❑	_____
Diabetes	❑	❑	_____
Ulcer	❑	❑	_____
Epilepsy	❑	❑	_____
Anemia	❑	❑	_____
Stroke	❑	❑	_____
Asthma	❑	❑	_____
Hernia	❑	❑	_____
Glaucoma	❑	❑	_____

FAMILY HISTORY

	No	Yes	Family Relationship (Father, Mother, Brother, Sister, Grandparent)
Pulmonary embolism	❑	❑	_____
Blood clots/DVT	❑	❑	_____
Diabetes	❑	❑	_____
Tuberculosis	❑	❑	_____
Lung Disease	❑	❑	_____
Heart Disease	❑	❑	_____
Stroke	❑	❑	_____
Kidney Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____
Cancer	❑	❑	_____
Bleeding Tendency	❑	❑	_____
Do you use alcohol?	❑	❑	

If yes, how often? _____ How long? _____

Have you ever used tobacco? ❑ ❑

Do you currently use tobacco? ❑ ❑

If yes, amount _____ How long? _____

If you have quit, how long ago? _____

MEDICATION INFO

	NAME	STRENGTH	DOSAGE
Prescribed	❑ Blood thinner		
	❑ Diet pills		
	❑		
	❑		
	❑		
	❑		
	❑		
	❑		
	❑		
	❑		
	❑		
	❑		
Over-the Counter	❑		
	❑		

Reviewed: _____

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REVIEW OF SYSTEMS

Please check if you have had any of these symptoms recently

CONSTITUTIONAL	NO	YES
Recent change in weight	❑	❑
How many pounds?		
Gained: _____		
Lost: _____		
Since when? _____		
Loss of appetite	❑	❑
Fever	❑	❑
Fatigue	❑	❑
Night sweats	❑	❑

HEAD		
Frequent headaches	❑	❑
Seizures	❑	❑
Head injury	❑	❑
(If yes, when? ____/____/____)		

EYES		
Trouble with vision	❑	❑
Wear corrective lenses	❑	❑

EARS, NOSE, AND THROAT		
Trouble hearing	❑	❑
Hoarse voice	❑	❑

GASTROINTESTINAL		
Heartburn	❑	❑
Feel bloated after eating	❑	❑
Have difficulty swallowing	❑	❑
Nausea and vomiting	❑	❑
Have vomited blood	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Black stools	❑	❑
Hemorrhoids	❑	❑
Rectal bleeding	❑	❑
Have pain in stomach	❑	❑
After eating?	❑	❑
Have pain elsewhere		
In abdomen	❑	❑

GENITO-URINARY		
Burning with urination	❑	❑
Blood in urine	❑	❑

MUSCULOSKELETAL	NO	YES
Stiff or painful joints	❑	❑
Muscle pain	❑	❑

RESPIRATORY		
Shortness of breath	❑	❑
Coughing	❑	❑
Coughing up blood	❑	❑
Wheezing	❑	❑
Bronchitis more than once per month	❑	❑

CARDIOVASCULAR		
Chest pain, or tightness	❑	❑
Difficulty in breathing	❑	❑
Heart palpitations	❑	❑
Have you had a stress test?	❑	❑
(If yes, when? ____/____/____)		
Physician/Cardiologist name:		

_____

SKIN		
Changes in coloration of your skin	❑	❑
Any lumps noticed:		
Under your arms?	❑	❑
Groin area?	❑	❑
Breast?	❑	❑

NEUROLOGIC		
Convulsions	❑	❑
Muscular weakness	❑	❑
Paralysis	❑	❑
Any loss of sensation, tingling, numbness, in your fingers, toes, limbs?	❑	❑

MOOD		
Depressed?	❑	❑
Anxious?	❑	❑
Trouble sleeping?	❑	❑

SLEEP		
Sleep Apnea	❑	❑
(If so, do you use CPAP?)	❑	❑
Date of last sleep study? _____/_____/_____		

Reviewed: _____ (rev. 08-13-2017) Patient: _____ Date: ____/____/____