Monterey County Surgical Associates

General Health Questionnaire

This is a confidential record of your medical history and will help us to provide the best care possible. Information contained here will not be released to any person unless authorized by you.

Name: _____ Age: _____ Today's Date: _____

Referring Doctor's name, address and phone number: _____

Other doctors who care for you - Names and addresses: _____

What medical condition brings you to this office? _____

General Medical History

List any previous operations you have had:

Operation	Date	Type of Anesthesia	Problem with anesthesia?
1.			
2.			
3.			
4.			

List any hospitalizations you have had for an illness not requiring surgery:

1.	4.
2.	5.
3.	6.

YES NO Have you ever had a blood or plasma transfusion?

Have you had any of the following problems?

- ☐ High blood pressure
- ☐ Irregular heart rhythm
- ☐ Heart attack
- ☐ High cholesterol
- ☐ Lung problems
- ☐ Stroke
- ☐ Seizure or Epilepsy
- ☐ Diabetes
- ☐ Kidney or Bladder problems
- ☐ Liver problems or hepatitis
- ☐ Cancer (specify type)
- ☐ Blot clot or embolus
- ☐ Abnormal bleeding/bruising
- ☐ Thyroid problems
- ☐ Rheumatoid arthritis
- ☐ Serious depression
- ☐ Other psychiatric illness
- ☐ Alcoholism
- ☐ Headaches
- ☐ Other (specify)

Medications and Allergies

Please list below all the medication you take, including those which do not require a prescription:
List medication (dose and times taken per day)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

List all medicatins you are **allergic** to, as well as medications or medical products to which you have had a bad reaction (e.g. rash to paper tape): Check here if you have no known allergies ☐

Medication/Product	Reaction
1.	
2.	
3.	
4.	

YES NO Have you taken steroids such as prednisone or cortisone in the last 6 months?

Have you ever smoked cigarettes?
☐ Never
☐ Yes, but I quit ____ years ago, and smoked approximately ____ packs per day for ____ years.
☐ Yes, I smoke ____ packs per day and have smoked for ____ years.

Do you drink alcoholic beverages?
☐ Yes, more than 7 drinks per week.
☐ Yes, less than 7 drinks per week.
☐ I used to but no longer.
☐ No

YES NO Do you presently use recreational or illegal drugs?

Family History of Illnesses

Do any of your blood relatives have the following problems?

	Relation to you	Type of problem
☐ Heart disease		
☐ Lung disease		
☐ Stroke		
☐ Kidney disease		
☐ Liver disease		
☐ Cancer (specify type)		
☐ Diabetes		
☐ Rheumatoid arthritis		
☐ Alcoholism		
☐ Serious mental illness		
☐ Other Illnesses that run in the family		

YES NO Have you or any of your blood relatives had a serious problem with anesthesia? Specify.

General Symptoms

Do you have any to the following symptoms?

☐ Chest pain
☐ Blackouts or fainting
☐ Palpitations or irregular heart beats
☐ Swelling of your ankles
☐ Shortness of breath walking up a flight of stairs
☐ Chronic cough or sputum (phlegm) production
☐ Blood in your sputum
☐ Black or tarry stools
☐ Diarrhea
☐ Frequent heartburn or regurgitation
☐ Frequent nausea or vomiting
☐ Frequent or new constipation
☐ Temporary loss or blurring of vision
☐ Hearing loss
☐ Facial weakness or numbness
☐ Episodes of weakness of one arm or leg
☐ Difficulty walking
☐ Arthritis or severe joint pains
☐ Back pain
☐ Excessive bleeding or bruising
☐ Recent weight loss or gain greater than 10 lbs.
☐ Burning with urination or frequent urination
☐ Serious depression
☐ Pregnancy

What is the heaviest physical activity you might do in a week? _____

Social History

With whom do you live? _____

What is your occupation? _____

Are there people for whom you are the primary caregiver? _____

Could someone care for you if you were seriously ill? _____

What hobbies do you have that are important to you? _____