Southwest Surgical Associates, LLP
Health History

Patient Name: _____, _____ ____ **DOB**_____
LAST **FIRST** **M.I.**

Chief Complaint: _____

Family Physician: _____**Allergies:**_____

_____ _____ _____ _____ _____
Age **Height** **Weight** **Home Telephone** **Other Telephone**

Past Medical History

SURGERY	**Yes**	**No**	**Date(s)**		**Yes**	**No**	**Date(s)**
Abdominal	_____	_____	_____	Rectal	_____	_____	_____
Gallbladder	_____	_____	_____	Tonsils	_____	_____	_____
Appendix	_____	_____	_____	Hysterectomy	_____	_____	_____
Thyroid	_____	_____	_____	Pregnancy	_____	_____	_____
*Other	_____	_____	_____	Breast	_____	_____	_____

*If Yes please list "others":_____

ILLNESS	**Yes**	**No**	**Date(s)**		**Yes**	**No**	**Date(s)**
Diabetes	_____	_____	_____	Cancer	_____	_____	_____
High Blood Pressure	_____	_____	_____	Respiratory Problems/ TB	_____	_____	_____
				High Cholesterol	_____	_____	_____
Liver Disease/ Hepatitis	_____	_____	_____	Heart Disease	_____	_____	_____
Epilepsy	_____	_____	_____				
*Other	_____	_____	_____				

*If Yes please list "others"_____

LIFESTYLE	**Yes**	**No**	**Amount**		**Yes**	**No**
Alcohol Use	_____	_____	_____	Drug Use	_____	_____
Cigarettes	_____	_____	_____	Sexually Transmitted Disease(s)	_____	_____

FAMILY HISTORY

	Yes	**No**	**Relationship**		**Yes**	**No**	**Relationship**
Cancer	_____	_____	_____	Bleeding Disorder	_____	_____	_____
Diabetes	_____	_____	_____	Mental Illness	_____	_____	_____
Heart Disease	_____	_____	_____	Epilepsy	_____	_____	_____
High Blood Pressure	_____	_____	_____	Tuberculosis	_____	_____	_____

List any medications you are taking:_____

_____

_____

Signature_____ Date _____