

Appt with Dr. _____

Referred by: _____

McHenry Medical Group

1541 Florida Avenue, Suite 200
Modesto, California 95350
Telephone 209-577-3388

Name: _____

Patient ID: _____

Date: _____

PATIENT QUESTIONNAIRE Surgery Department Intake Form

Who is your primary care doctor?

Referred to surgeon by:

Names of other doctors you see:

REASON FOR VISIT:

List all allergies to medications or foods and your reaction:

ALLERGY	Reaction

ALLERGY	Reaction

List all medications you are taking — prescription and over the counter:

Name of MEDICATION	Dosage	Frequency

Name of MEDICATION	Dosage	Frequency

CURRENT AND PAST MEDICAL CONDITIONS (check all that apply)

	Yes	No
Asthma		
COPD (emphysema)		
Diabetes mellitus		
Hypertension		
Coronary artery disease		
Acute MI (heart attack)		
Stroke		
Osteoporosis		
Alzheimer's dementia		
Anxiety disorder		
Pancreatitis		
Jaundice		
Cirrhosis		
Breast cancer		
Ovarian cancer		
Colon cancer		
Cancer, other		
Hyperlipidemia (high cholesterol)		
Irritable bowel syndrome		
GERD (gastroesophageal reflux)		
Peptic ulcer disease		

	Yes	No
Osteoarthritis		
Depression		
Epilepsy (seizures)		
Glaucoma		
HIV infection		
Renal (kidney) disorders		
Hepatic (liver) disorders		
Respiratory (lung) disorders		
Psychiatric disorders		
Sleep apnea		
Migraine headache		
Sickle cell anemia		
Thyroid disorders		
Tuberculosis		
Hepatitis, unknown type		
Hepatitis A, B, C (circle)		
Heart murmur		
Prolapsing mitral valve		
Other:		

Have you had any of the following conditions?

Thrombophlebitis (blood clots with inflammation) in the deep vessels of the legs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thrombosis (blood clot)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pulmonary embolism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	MRSA (staph infection)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bleeding problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Female patients only

Currently pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you using birth control pills?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Age at first pregnancy:			Age at first period:		
Number of pregnancies:			Do you have regular periods?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Number of deliveries:			Date of last period:		
Number of miscarriages or abortions:			Do you have abnormal periods?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever nursed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Childhood diseases (check all that apply)

Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chickenpox (varicella)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other:					

SURGICAL HISTORY (check all that apply)

	Yes	No		Yes	No
Blood transfusion					
If yes, complications?					
Adverse reaction to anesthesia?					
Gallbladder removal, open surgery			Repair of abdominal wall		
Gallbladder removal, laparoscopic			Hernia repair		
Appendectomy			Inguinal hernia		
Tonsillectomy			Femoral hernia		
Thyroid surgery			Umbilical hernia		
Diagnostic laparoscopy			Incisional hernia		
Ulcer surgery			Ventral hernia		
Abdominal aortic aneurysm repair			Breast surgery		
Small bowel resection			Lumpectomy		
Colon (large intestine) surgery			Mastectomy		
Hemorrhoidectomy			Breast reconstruction		
Anal sphincterotomy			Benign breast biopsy		
Splenectomy (spleen removal)			Breast augmentation		
Coronary artery bypass grafting			Dilation and curettage (D&C)		
Lung surgery			Tubal ligation		
Kidney surgery			Hysterectomy		
Bladder surgery			with removal of ovaries		
Orthopedic surgery			without removal of ovaries		
Location/limb:			Cesarean section delivery		
Other:					

FAMILY HISTORY

	<i>Living</i>	<i>Deceased</i>	<i>Age</i>	<i>Major Illnesses/Cause of Death</i>
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

FAMILY HISTORY, continued (check yes if anyone in your family has ever had the condition)

	Yes	No		Yes	No
Diabetes mellitus			Asthma		
Hypertension			Allergies		
Heart disease			Adverse reaction to anesthesia		
Heart attack			Arthritis		
Stroke			Alcoholism		
Kidney disease			Migraine headache		
Liver disease			Anxiety disorder		
Lung disease			Depression		
Pulmonary embolism (clot in lung)			Mental disorder		
Thyroid disorder			Alzheimer's dementia		
Bleeding problems			Epilepsy (seizures)		
Blood clot (thrombosis)			Glaucoma		
Phlebitis (inflammation of a vein)			HIV infection, AIDS		
			Sickle cell anemia		
Cancer*					

* Indicate type and family member if known:

	Father	Mother	Brother	Sister	Grandfather		Grandmother	
					Paternal	Maternal	Paternal	Maternal
Breast cancer								
Ovarian cancer								
Colon cancer								
Other cancer								

SOCIAL HISTORY

	Yes	No	Amount	
Alcohol use				Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>
Tobacco use				Living with spouse <input type="checkbox"/> Living with parent(s) <input type="checkbox"/>
Former smoker?				Living alone <input type="checkbox"/> Living with caregiver <input type="checkbox"/>
Recreational drug use				In assisted-living facility <input type="checkbox"/>
Caffeine use				
Coffee				Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/>
Tea				Occupation:
Cola				Recent travel?

REVIEW OF SYSTEMS

<i>General</i>	Yes	No
Weight gain or loss (circle one)		
How much? Over what time period?		
Chills		
Fever		
Night sweats		
Feeling tired		
<i>Eyes</i>		
Vision problems		
Sensitivity to light (photophobia)		
Eye pain		
Itching		

<i>Head</i>	Yes	No
Headache		
Facial pain		
Sinus pain		
<i>Ears, Nose, Throat</i>		
Earache		
Hearing loss		
Ringling in ears		
Nosebleeds		
Nasal discharge		
Mouth sores		
Bleeding gums		
Hoarseness		
Throat pain		

