

Dalton Surgical Group Health Questionnaire

Today's Date _____

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____

Reason for today's visit: _____

Physician/Person who referred you here: _____

Other Physicians you see: _____

How long have you been aware of this problem? _____

When does this problem occur? _____

What things make problem better? _____

What things make problem worse? _____

How much does this affect you? _____ Minimal _____ Moderate _____ Severe

LIST ALL MEDICATIONS (or state NONE): _____

LIST ANY ALLERGIES to medications (or state NONE): _____

Are you allergic to LATEX? YES NO

Check all that apply to you:

- Asthma
- Autoimmune Disease
- Cancer
- Coronary Artery Disease
- Deep Vein Thrombosis/Blood Clots
- Diabetes
- Diverticulitis
- Do you take Aspirin?
- Do you take Blood Thinners?
- Gout
- Heart Disease
- High Blood Pressure/Hypertension
- High Cholesterol
- Hepatitis
- Hyperthyroidism
- Hypothyroidism
- Liver Disease
- Pulmonary Embolism
- Seizures/Epilepsy
- Sleep Apnea
- Stroke
- Tuberculosis

Check all that apply to you:

- Fever
- Night sweats
- Weight gain _____ lbs
- Weight loss _____ lbs
- Exercise intolerance
- Dry eyes
- Eye irritation
- Vision changes
- Currently wears gasses/contacts
- Difficulty hearing
- Ear pain
- Frequent nose bleeds
- Nose/sinus problems
- Sore throat
- Bleeding gums
- Snoring
- Mouth/oral problems
- Oral ulcers
- Teeth problems
- Throat hoarseness
- Chest pain on exertion
- Leg pain on exertion
- Shortness of breath when walking
- Shortness of breath when lying down
- Palpitations
- Known heart murmur
- Light-headed on standing
- Varicose veins
- Hypertension
- Coughing
- Wheezing
- Shortness of breath
- Coughing up blood
- Sleep apnea
- COPD
- Abdominal pain
- Vomiting
- Change in appetite
- Black stool
- Frequent diarrhea
- Vomiting blood
- Indigestion
- GERD
- Change in bowel/bladder habits
- Hepatitis/exposure to hepatitis
- Loss of urinary control
- Difficulty urinating
- Increased urination
- Blood in urine
- Unable to empty bladder
- Muscle aches
- Muscle weakness
- Joint pain
- Back pain
- Swelling of extremities
- Abnormal mole
- Jaundice
- Rash
- Itching
- Dry skin
- Growths/lesions
- Laceration
- Loss of consciousness
- Weakness
- Seizures
- Dizziness
- Frequent or severe headaches
- Migraines
- Restless legs
- Depression
- Sleep disturbance
- Restless sleep
- Alcohol abuse
- Fatigue
- Increased thirst
- Hair loss
- Increased hair growth
- Cold intolerance
- Heat intolerance
- Diabetes Type 1
- Diabetes Type 2
- Swollen glands
- Bruising
- Bleeding problems
- Anemia
- Blood clots
- Blood transfusion
- HIV/AIDS

List Any Previous Surgeries or state "NONE"

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Family History- Please check all that apply for your Father, Mother, Sibling, or Grandparent

Diabetes

___ Father ___ Mother ___ Sibling ___ Grandparent

Blood Disorder

___ Father ___ Mother ___ Sibling ___ Grandparent

High Blood Pressure

___ Father ___ Mother ___ Sibling ___ Grandparent

Gallbladder Problems

___ Father ___ Mother ___ Sibling ___ Grandparent

Thyroid Problems

___ Father ___ Mother ___ Sibling ___ Grandparent

Anesthesia Problems

___ Father ___ Mother ___ Sibling ___ Grandparent

Cancer

___ Father ___ Mother ___ Sibling ___ Grandparent

Social History

Alcohol Use ___ None ___ Occasionally ___ Moderate ___ Heavy

Tobacco Use ___ Never ___ Former ___ Current Everyday ___ Packs per day

Patient Signature

Date

Print Patient Name

Date of Birth