Wake Forest Baptist Health
General Surgery
Health Assessment

Wake Forest Baptist Health

Name:_____ **Date of Birth:** _____

Sex: ○ **Male** ○ **Female** Age:___ Race:_____

Medical doctor Name & Address (PCP):_____
_____

Referring
Physician Name & Address:_____
_____

Other Medical Doctors/Type:_____
_____

Cell Phone:_____
E-Mail Address:_____

DRUG ALLERGIES

List any allergies that you have:_____
_____
_____

MEDICATIONS: Please list and bring all medications with you to your appointment.

MEDICAL CONDITIONS

○ **YES** ○ **NO** Heart disease		○ **YES** ○ **NO** High Cholesterol	
○ **YES** ○ **NO** High blood pressure		○ **YES** ○ **NO** Aneurysm disease	
○ **YES** ○ **NO** Vascular disease		○ **YES** ○ **NO** Stroke	
○ **YES** ○ **NO** Hepatitis		○ **YES** ○ **NO** Prior Vascular Surgery	
○ **YES** ○ **NO** COPD		○ **YES** ○ **NO** Joint Disease/Arthritis	
○ **YES** ○ **NO** Depression		○ **YES** ○ **NO** Gynecological Problems	
○ **YES** ○ **NO** Sleep Apnea		○ **YES** ○ **NO** Irritable Bowel Syndrome	
○ **YES** ○ **NO** Stress Incontinence		○ **YES** ○ **NO** Acid Reflux/Heartburn	
○ **YES** ○ **NO** Lung disease		○ **YES** ○ **NO** Possible DVT/PE	
○ **YES** ○ **NO** Kidney disease			
○ **YES** ○ **NO** Bleeding problems			
○ **YES** ○ **NO** Diabetes			
○ **YES** ○ **NO** Other Medical Problems:(list) _____			

○ **YES** ○ **NO** Have you ever had chemotherapy or radiation?
If you answered YES, what was the date of your last: Chemotherapy treatment_____
:Radiation treatment_____

○ **YES** ○ **NO** Have you lost weight in the last 6 months?
○ **YES** ○ **NO** Were you trying to lose weight?
_____ How much weight have you lost?

○ **YES** ○ **NO** Do you get short of breath walking up the stairs?
○ **YES** ○ **NO** Do you get short of breath when resting or trying to complete a sentence?
○ **YES** ○ **NO** Have you been short of breath in the last 30 days?

PAST SURGICAL HISTORY
Since your last physical examination, have you had any major illnesses, hospitalizations, surgeries, pregnancies or injuries:_____**YES** _____**NO**

If **YES**, please list:_____

_____

_____

Anesthesia Problems: _____Yes _____No

SURGICAL HISTORY:

List all Surgeries and Dates:

Surgery	**Dates**

SOCIAL HISTORY:

Do you smoke cigars or cigarettes? **Yes** **No** (If yes circle which product or both)
How many per day do you smoke? Cigars_____ Cigarettes_____
How many years have you smoked?_____

If you don't currently smoke, have you ever smoked in the past? **Yes** **No**
Have you smoked cigars or cigarettes within the past year? **Yes** **No**
How many packs of cigarettes did you smoke before quitting?_____

Do you drink alcohol? **Yes** **No**
How many ounces of hard liquor do you drink per week?_____
How many glasses of wine do you drink per week?_____
How many cans of beer do you drink per week?_____

Have you ever used illegal drugs? **Yes** **No**
Are you now or have ever been a victim of abuse or neglect? **Yes** **No**

Marital Status **Single** **Married** **Divorced** **Widowed**
Occupation_____
Where do you live?_____

Daily Living: Please circle all that apply:
Do you use any of the following devices to help you in your daily living? **Cane** **Wheelchair** **Walker** **Artificial Limbs**

Do you need help from another person when **Bathing, Dressing, Feeding, Toileting, Walking** or **Standing?**

FAMILY HISTORY

Do any **blood relatives** *(primarily interested in brother, sister)* have the following?

- **Diabetes** _____
- **Heart Attacks (under 50 years old)** _____
- **Cancer (under 40 years old)** _____
- **High Blood Pressure** _____

REVIEW OF SYSTEMS:

Do you currently have trouble with any of the following on a regular basis?

General:
Good general health lately No Yes
Recent weight change No Yes
Fever No Yes
Chills No Yes
Night sweats No Yes
Fatigue No Yes
Sleep problems No Yes
Loss of appetite No Yes

Eyes:
Vision difficulty No Yes
Concerns about eyes No Yes

Ears/Nose/Throat:
Hearing difficulty No Yes
Sinus Problems No Yes
Nose or throat concerns No Yes

Cardiovascular
Chest pain No Yes
Palpitations/Irregular heartbeat No Yes
Shortness of breath lying flat No Yes
Swelling of legs No Yes

Respiratory
Frequent cough No Yes
Coughing up blood No Yes
Shortness of breath No Yes
Wheezing No Yes

Gastrointestinal
Abdominal pain or heartburn No Yes
Change in bowel patterns No Yes
Blood in stool No Yes
Black tarry stool No Yes
Nausea or vomiting No Yes
Frequent diarrhea No Yes
Constipation No Yes
Trouble swallowing No Yes

Genitourinary
Frequent urination No Yes
Burning or painful urination No Yes
Blood in urine No Yes
Incontinence or dribbling No Yes
Trouble initiating stream No Yes
Weak urine stream No Yes

Genitourinary (contd.):
Sexual difficulty or concerns No Yes
Female – do you still have a menstrual cycle? No Yes
Female – age at time of last menstrual cycle _____
Female – irregular menstrual cycles No Yes
Female – hot flashes No Yes
Female – breast pain or discharge No Yes

Musculoskeletal:
Joint pain No Yes
Joint stiffness or swelling No Yes
Muscle pain No Yes
Back pain No Yes

Skin:
Rash No Yes
Itching No Yes
Suspicious lesions or spots No Yes
Hair loss No Yes

Neurologic:
Frequent headaches No Yes
Localized weakness No Yes
Numbness No Yes
Lightheaded or dizzy No Yes

Psychiatric:
Depression No Yes
Frequently sad or blue No Yes
Loss of interest in activities No Yes
Anxiety/nervousness No Yes

Endocrine:
Excessive thirst or urination No Yes
Heat or cold intolerance No Yes

Hematology/Lymphatic:
Easy bruising or bleeding No Yes
Enlarged glands or lumps No Yes

Allergic/Immunologic:
Hay fever No Yes
Hives No Yes
Food allergies No Yes

PREVENTIVE SERVICES: have you ever had the following tests? If so, when was it last done?

Mammogram	No Yes	Year_____	Colonoscopy	No Yes	Year_____
Breast Exam	No Yes	Year_____	Tetanus shot	No Yes	Year_____
PAP Smear	No Yes	Year_____	Pneumonia vaccine	No Yes	Year_____
PSA (Prostate)	No Yes	Year_____	Flu shot	No Yes	Year_____

Patient signature:_____ Date:_____

I have reviewed this ROS, SH, FH, PMH:

Physician signature:_____ Date:_____

Revised 2-25-13