Alamo City Surgeons **Health History**

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

Allergies (Medications, Latex, Foods): _____ _____ _____

Medications/Supplements	Dose/Strength	How many times per day

Past Medical:

Surgeries:
Prior illness or other major illnesses:

Diabetes: ☐ Y or ☐ N High Blood Pressure: ☐ Y or ☐ N History of Blood Clots: ☐ Y or ☐ N

Heart Disease/History of Heart Attack: ☐ Y or ☐ N

History of Cancer: ☐ Y or ☐ N If yes, Type: _____ Year Diagnosed: _____

Mammogram done: ☐ Y or ☐ N
Date: _____
Referred to PCP: _____

Colonoscopy done: ☐ Y or ☐ N
Date: _____
Referred to PCP: _____

Do you have a history of a problem with Anesthesia? ☐ Y or ☐ N

Family:

Health status or death of parents: _____

Health status or death of siblings: _____
Number of children: _____
Family History of Bleeding: _____
Family History of Cancer: _____ Breast: _____ Colon: _____ Thyroid: _____
Family History of complications to anesthesia: _____

Social:

Marital status: ☐ Single ☐ Married/Partner ☐ Widowed ☐ Divorced ☐ Prefer not to answer

Current employment: _____
Do you smoke tobacco? ☐ Y or ☐ N Alcohol use: ☐ Y or ☐ N If yes, # of drinks per wk: _____
Do you use recreational drugs? ☐ Y or ☐ N
Have you ever used needles to injected drugs? ☐ Y or ☐ N

Comprehensive PFSH taken during a previous encounter was re-examined and reviewed with the patient. No changes since last visit.

Refer to history on Date of service: _____ Located in office medical record.

Office Use Only:

PFSH: Detailed - requires 1 specific item from 1 of the 3 areas (past, family, social)
Comprehensive - requires at <u>least</u> 1 item from <u>each</u> of the 3 areas
Physician must review history. Physician should state if Relevant or Not Relevant to CC

Physician's signature: _____ **Date:** _____