Surgery/NeuroSurgery

USF HEALTH

PATIENT HISTORY FORM

Reason for visit:______________________________

Date of visit: _________________

Referring Physician: ___________________
Address: _____________________________
____
____

Patient Medical History

Previous Hospitalizations/Surgeries/Serious Injuries:

Current Prescription and Over the Counter Medications:

Any Known Drug Allergies? ____ *Type of reaction:* ___________________________

Date of last Immunization: Tetanus _____________________ Hep B Series ___________________________
Flu Shot _____________________ PPD (TB Test) _________________________

Patient Social History

(please circle one)	Male	Female			
Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously, but quit		Current, packs/day ___________	
Use of Drugs:	Never	Type/Frequency: ___________________________			

Occupation: ____

Family Medical History

	Age	Any Disease/Conditions Past/Present	If deceased, cause of death
Father	_______	______________________	______________________
Mother	_______	______________________	______________________
Sibling	_______	______________________	______________________
	_______	______________________	______________________
	_______	______________________	______________________
Children	_______	______________________	______________________
	_______	______________________	______________________

Review of Systems *(please circle any of the listed symptoms that are current or past problems for you)*

Constitutional:	Fever	Chills	Weight loss or gain	Fatigue	
Eyes:	Double Vision	Blurry Vision	Need for glasses	Glaucoma	Injury or surgery
Ear, Nose, Throat:	Sinusitis	Hearing Loss	Ringing in Ears	Sores Voice change	Swelling
Cardiovascular:	Heart attack	Chest Pain	High Blood pressure	Palpitations	Leg Swelling
Respiratory:	Shortness of breath	Asthma	Cough	Spitting up blood	Wheezing
Gastrointestinal:	Loss of appetite	Nausea	Vomiting	Abnormal bowel movements	Pain
Genitourinary:	Frequent or painful urination		Incontinence	Infections	Irregular menses
Musculoskeletal:	Joint pain or stiffness		Weakness	Injury or surgery	Swelling
Skin/Breast	Rashes	Ulcers	Nail Changes	Breast pain or lump Or discharge	
Neurological:	Stroke or TIA	Headaches	Dizziness	Seizures	Loss of Balance
Psychological:	Memory Loss	Depression	Insomnia	Nervousness	
Endocrine:	Diabetes	Thyroid problem		Excessive thirst or urination	
Hematologic:	Bleeding or bruising tendency		Phlebitis	DVT	Transfusion
Infection:	Hepatitis A B C		HIV/AIDS		

Other Pertinent ROS

Patient's Signature: ________________________________ ***Physician's Signature:*** ________________________