UW Medicine

SURGICAL SERVICES & HERNIA CENTER

NORTHWEST HOSPITAL

Patient Label

Health History Form

DATE: _____

NAME: Last _____ **First** _____ **MI**_____**Gender:** ☐ **M** ☐ **F Birthdate:** _____

PREFERRED NAME: _____ **EMAIL ADDRESS:** _____

REFERRING PROVIDER: _____ **SPECIALITY:**_____

PRIMARY CARE PROVIDER: _____ **PREFERRED PHARMACY:** _____

REASON FOR TODAY'S VISIT: _____

Allergies:	**Medication or Substance**	**Reaction**
(include meds, food,		
latex, or iodine)		
☐ No Allergies		

Current Medicine:	**Label – Name**	**Dose**	**Frequency**
OR			
☐ See attached list			

Social History

☐ Single ☐ Married (their name: _____) ☐ Domestic Partner (their name: _____) # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used injected/IV drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone)

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

Women's Health

	Yes	**No**	
Never Pregnant	☐	☐	# of pregnancies_____ # deliveries_____ # full term births_____
Currently Pregnant	☐	☐	# of weeks _____
Menstrual Period	☐	☐	First day of last period _____ Period occurs every _____days
			Age of first period _____
			Cramps: ☐ Mild ☐ Moderate ☐ Severe
			Flow: ☐ Light ☐ Moderate ☐ Heavy
			Spotting between periods: ☐ Yes ☐ No
Menopause	☐	☐	Age _____
			If menopausal, have you ever used a hormone replacement?
			☐ Yes ☐ No If so, what was used? _____

UW Medicine

SURGICAL SERVICES & HERNIA CENTER

NORTHWEST HOSPITAL

Patient Label

Health Maintenance

	Yes	No		
Flu	☐	☐	When _____	Where _____
Pneumovax	☐	☐	When _____	Where _____
Pap Smear	☐	☐	Date _____	Result _____
Mammogram	☐	☐	Date _____	Result _____
Colonoscopy	☐	☐	Date _____	Result _____
Do you exercise?	☐	☐	Frequency_____	Type _____

Specialty Medical History — Please check box for those conditions you have now or have ever

☐ Abnormal ECG
☐ Alcoholism
☐ Anal Fissure
☐ Anesthesia Problems
☐ Arrhythmia
☐ Barrett's Esophagus
☐ Breast Mass
☐ Burns
☐ Cancer
☐ Cholelithiasis
☐ Cirrhosis
☐ Colon Cancer
☐ Colon Polyps
☐ Coronary Atherosclerosis
☐ Deep Vein Thrombosis
☐ Diabetes Mellitus
☐ Diverticulitis
☐ Emphysema
☐ Fibrocystic Breast
☐ Gastric Ulcer
☐ Groin Hernia
☐ Hemangioma
☐ Hiatal Hernia
☐ Liver Disease
☐ Liver Mass
☐ Obesity
☐ Obstructive Sleep Apnea
☐ Pacemaker/Implanted Defibrillator
☐ Pancreatitis
☐ Pulmonary Arterial Hypertension
☐ Pulmonary Embolism
☐ Pulmonary Hypertension
☐ TIA
☐ Trauma
☐ Ventral or Incisional Hernia
☐ Wound Dehiscence
☐ Wound Infection

General Medical History — Please check box for those conditions you have now or have ever

☐ No Past Medical History
☐ Allergic Rhinitis
☐ Anemia
☐ Anesthesia Problems
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding/Clotting Disorder
☐ Blood Transfusion
☐ Cancer
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Atherosclerosis
☐ Depression
☐ Diabetes Type 1
☐ Gastric Ulcer
☐ GERD
☐ Glaucoma
☐ GYN
☐ Headache
☐ Heart Murmur
☐ Hepatitis
☐ HIV
☐ Hypertension
☐ Insomnia
☐ Kidney Disease
☐ Lipid/Cholesterol
☐ Lung Disease
☐ Musculoskeletal
☐ Myocardial Infarction
☐ Osteoporosis
☐ PPD
☐ Seizures
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disease
☐ Tuberculosis

Surgical History — Please check box for any surgery you have had, indicate the year

☐ No Past Surgical History
☐ Adrenalectomy (_____)
☐ Anorectal Surgery (_____)
☐ Anti-Reflux Surgery (_____)
☐ Appendectomy (_____)
☐ Bariatric Surgery (_____)
☐ Breast Surgery (_____)
☐ CABG (_____)
☐ Cholecystectomy (____)
☐ Colon Resection (____)
☐ Colonoscopy (____)
☐ Cosmetic Surgery (____)
☐ Esophageal Myotomy (____)
☐ Hemorrhoidectomy (____)
☐ Hernia Repair (____)
☐ Hysterectomy (____)
☐ Joint Replacement (____)
☐ Laparotomy (____)
☐ Liver Resection (____)
☐ Pancreas Resection (____)
☐ Prostate Surgery (_____)
☐ Small-Bowel Resection (___)
☐ Splenectomy (_____)
☐ Thyroidectomy (_____)
☐ Tubal Ligation (_____)
☐ Valve Replacement (_____)

☐ Other:_____

_____

Complications from Anesthesia ☐ No ☐ Yes Please explain. _____

UW Medicine

SURGICAL SERVICES & HERNIA CENTER

NORTHWEST HOSPITAL

Patient Label

Family History–Check all that apply

Relationship	First Name	Status (circle)	No Known Problems	Alcohol/Drug Abuse	Aneurysm	Arthritis	Asthma	Birth Defects	Bleeding Disorder	Cancer	Clotting Disorder	Colitis	COPD	Deep Vein Thrombosis	Depression	Diabetes	Early Sudden Death	Hearing Loss	Heart Disease	Hernia	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disability	Lipids/High Cholesterol	Mental Illness	Intellectual Disability	Miscarriages	Obesity	Polyps	Stroke	Thyroid Disease	Vision Loss	Osteoporosis
Mother		alive deceased																															
Father		alive deceased																															
Sister		alive deceased																															
Brother		alive deceased																															
Maternal Grandmother		alive deceased																															
Maternal Grandfather		alive deceased																															
Paternal Grandmother		alive deceased																															
Paternal Grandfather		alive deceased																															

Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

Review of Systems (current symptoms) – please check only if these are bothering you at this time

System	Symptom	Comments
General	☐ Recent Weight Gain/Loss ☐ Fatigue/Trouble Sleeping ☐ Fever/Chills/Night Sweats	
Ear/Nose/Mouth/Throat	☐ Hearing Loss/Hearing Aid ☐ Ear Problems ☐ Nose Problems ☐ Mouth or Throat Problems ☐ Nose Bleeds/Sinus Problems ☐ Dental Problems/Dentures ☐ Loose or Missing Tooth/Teeth	
Eye	☐ Wear Glasses/Contacts ☐ Eye Problems ☐ Yellowing of White Part of Eyes	

UW Medicine

SURGICAL SERVICES & HERNIA CENTER

NORTHWEST HOSPITAL

Patient Label

Review of Systems Continued (current symptoms) – please check only if these are bothering you at this time

System	Symptom	Comments
Neurology	☐ Problems with Vision ☐ Headaches/Dizziness ☐ Seizures ☐ Fainting/Unconsciousness ☐ Numbness/Tingling/Weakness	
Heart	☐ Chest Pain ☐ Heart Murmur ☐ High Blood Pressure ☐ Recent Heart Attack/MI ☐ Artificial Heart Valve(s) ☐ Able to Walk Two Flights of Stairs	
Lung	☐ Shortness of Breath (day or night) ☐ Asthma ☐ Sleep Apnea/Snoring ☐ Difficulty Sleeping ☐ Lung Problems ☐ Recent Cold or Cough	
Skin	☐ Masses/Bumps/Lumps ☐ Rashes ☐ Lesions/Cuts/Scrapes ☐ Wounds/Blisters	
Stomach/ Gastrointestinal/ Colon/Rectum	☐ Stomach/Abdominal Pain ☐ Hiatal Hernia ☐ Heartburn/Indigestion ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in Stool ☐ Jaundice/Yellowing of skin ☐ Hepatitis	
Muscles/Bones	☐ Joint Pain ☐ Back Pain/Disc Disease ☐ Sprain/Strain ☐ Stiffness/Arthritis ☐ Artificial Joint(s) ☐ Other Physical Disability	
Urinary Tract Male/Female Issues Reproduction	☐ Urinary Problems ☐ Pain with Urination ☐ Kidney Problems/Kidney Stones ☐ Male or Female Specific Problems ☐ Females-Could you be pregnant?	
Blood/ Lymph	☐ Bleeding Problems ☐ Anemia ☐ Swollen or Enlarged Glands	
Immunological	☐ Hay Fever ☐ Allergies ☐ HIV/Aids	
Endocrine	☐ Heat/Cold Intolerance ☐ Hyperthyroid/Hypothyroid ☐ Increased Thirst/Diabetes	
Mental Health	☐ Anxiety/Depression ☐ Psychiatric Care ☐ Other Concerns	