Patient Health History

SONORAN SKY SURGICAL

Name: _____ Birthdate: _____ Today's Date: _____
Reason for today's visit: _____
Allergies: _____

Current and Past Medical Problems (initial line if yes, please circle/provide details requested):

_____ **Diabetes**: Type 1 Type 2 What/when was your last HgbA1c: _____
_____ **Heart Disease**: Heart attack Heart failure Heart stents Valve problems Other: _____
_____ **High Blood Pressure**
_____ **Neurologic Problems**: Stroke or TIA (mini-stroke) Epilepsy Seizures Dementia Other: _____
_____ **Cancer**: Type, how treated, cured or remission? _____
_____ **Lung Disease**: Emphysema COPD Asthma Other: _____ Oxygen use?: _____
_____ **Kidney Problems**: What kind? _____
_____ **Intestinal problems**: Diverticulitis Ulcers Ulcerative Colitis Crohn's Disease Irritable Bowel Syndrome Chronic diarrhea Chronic constipation Hemorrhoids Other: _____
_____ **Liver disease**: Cirrhosis Hepatitis (type ?): _____ Other: _____
_____ **Blood Problems**: Anemia Low platelets Low WBC Clotting disorders Other: _____
_____ **Blood clots**: DVT (legs) Pulmonary embolism (lungs) When/circumstance?: _____
_____ **Thyroid Disease**: Hyperthyroid Hypothyroid Other: _____
_____ **Autoimmune disease**: Lupus Scleroderma Psoriasis MS Rheumatoid Arthritis Other: _____
_____ **Vision Problems**: Glaucoma Macular degeneration Legal blindness Other: _____
_____ **Mental Health Problems**: Anxiety Depression Bipolar disease Schizophrenia Other: _____
_____ **Other**: _____

Prior Surgeries (include surgeon name and date) and/or Hospitalizations (for what and when):

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all medications and dose (including over-the counter and supplements/vitamins):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Tobacco: None If Yes, packs per day: _____ How many years: _____ If quit, when: _____ Vape?: _____
Alcohol Use: None Number of drinks per day or week (circle one): _____ How many years sober: _____
Illicit drug use (including marijuana): What: _____ How often: _____
How many years: _____ Former use?: _____

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Review of Systems (please circle if you have any of the following on a regular basis):

Constitutional: Fever Chills Night Sweats Fatigue Wt Loss, How much?: _____ Wt gain, How much?: _____

Eyes: Blurred vision Decreased vision Eye discharge Yellowed coloration

Ears/Nose/Throat: Decreased hearing Ringing Ears Nasal Congestion Sore Throat

Respiratory: Shortness of breath Cough Coughing up blood Wheezing

Cardiovascular: Chest pain/pressure Palpitations Irregular heartbeat Swollen Ankles

Gastrointestinal: Abdominal pain Blood in stools Black/tarry-looking stools Change in bowel habits Constipation Diarrhea Heartburn Loss of Appetite Nausea Vomiting Bloating

Genitourinary: Painful urination Blood in urine Urinary frequency Urinary incontinence Slow stream/straining

Breast: Lumps/masses Nipple discharge/bleeding Breast pain

Skin: Rash Itching Changes in moles Yellowing of skin

Neurologic: Dizziness Headaches/migraine Memory Loss

Psychiatric: Anxiety Depression Sleeping problems

Endocrine: Cold intolerance Heat intolerance Excessive thirst Excessive hunger

Musculoskeletal: Back Pain Joint Pain Muscle Weakness Neck Pain

Blood/lymphatics: Easy bruising Easy bleeding Swollen/painful lymph nodes Extremity swelling

Last colonoscopy: _____ Last mammogram: _____ Last gynecologic exam: _____

Family History:

Relative	Current Age	Age of Death	Health Problems (including type of cancer)
Mother			
Father			
Daughter			
Son			
Sister			
Brother			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Maternal aunt/uncle			
Paternal aunt/uncle			

Whom do you live with?: _____

Occupation: _____ Employer: _____ Education Level: _____

Is there any other information you feel it is important for us to know?

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold Sonoran Sky Surgical, PLC or any staff responsible for errors or omissions that I may have made in the completion of this form. I acknowledge that errors or omissions in terms of my health information could result in negative outcomes.

Patient/Guardian Signature: _____ Date: _____