

**LAKEVIEW SURGERY PATIENT HISTORY**

NAME: \_\_\_\_\_

Date: \_\_\_\_\_

What problems bring you into the office today? \_\_\_\_\_  
\_\_\_\_\_

Please list all other Medical Problems:  
\_\_\_\_\_  
\_\_\_\_\_

Please list all previous surgeries: (last 5-10 years)  
\_\_\_\_\_  
\_\_\_\_\_

Have you experienced any complications from surgery? YES \_\_\_\_\_ NO \_\_\_\_\_  
Please list ALL medications that you currently take: Allergies to ANY / ALL Medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you or have you every used tobacco or alcohol? (circle) YES / NO Current User? YES / NO  
Tobacco, #of years \_\_\_\_\_, Alcohol, # of years \_\_\_\_\_.

**Do you have a family history of:** (circle) Heart Disease, High Blood Pressure, Diabetes, Thyroid problems, Anemia, Asthma, Arthritis, TB, Hernias, Gall Bladder Disease.  
**Do you have a family history of Cancer?** YES / NO What kind of Cancers? (if known) \_\_\_\_\_  
\_\_\_\_\_

**Do you have a disease that runs in your family?** \_\_\_\_\_  
\_\_\_\_\_

- Have you or do you experience any of the following symptoms or problems? (circle)
1. Seizures, loss of consciousness, chronic headaches, hearing loss, dizziness, inner ear problems, change in vision, sinus problems, nose bleeds, sore throat, sores in mouth, chronic neck pain.
  2. Shortness of breath, cough, wheezing, pneumonia or bronchitis. Chest pain, palpitations, ankle swelling, shortness of breath while sleeping.
  3. Change in appetite, abdominal pain, nausea, vomiting, change in bowel habits, diarrhea, constipation, blood in stools, black colored stools, incontinence of stool.
  4. Difficulty or pain in urination, blood in urine, prostate problems, kidney stones incontinence or urine, sexually transmitted disease.
  5. Chronic back pain, joint problems, muscle pain or weakness, trouble with ambulation.
  6. Chronic fever's or chills, night sweats, unexplained weight loss or weight gain.
  7. **Female patients only:** Vaginal discharge or abnormal bleeding, pelvic pain, irregular or abnormally painful periods. # of pregnancies \_\_\_\_\_, # of deliveries \_\_\_\_\_, date of last menstrual period \_\_\_\_\_, age of menstruation \_\_\_\_\_, age of first live birth \_\_\_\_\_.