John L. Birbari, MD, FACS

Patient History Form

Date: ______________________

Patient name: ____ **Date of birth:** ____________________

Referred by: ________________________________ **Primary Care Physician:** ___________________________

New patient: ☐ Yes ☐ No **Post operative patient:** ☐ Yes ☐ No

Reason for visit: ____

Surgery performed (if applicable): ____________________________________ _**Date of surgery:** _______________

List of current medications: ____

____

____ ________☐ **List provided**

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please list medications: ____

Do you have any allergies to latex products? ☐ Yes ☐ No

Personal Medical History: Please list all conditions/illnesses (ex. Diabetes, asthma, cancer, COPD, etc.)

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____

Prior surgeries and approximate dates:

Surgery: ____ **Date:** ________________

Surgery: ____ **Date:** ________________

Surgery: ____ **Date:** ________________

Surgery: ____ **Date:** ________________

Do you now or have you ever used any tobacco products? ☐ Yes ☐ No **If yes, please answer the following:**

Type of tobacco used: ______________ **Amount and frequency:** ________________ **Age started:** __________

Number of years used: _____________ **Have you quit?** ☐ Yes ☐ No **When?** _____________

Do you drink alcohol? ☐ Yes ☐ No **Type:** ___________________ **Number of drinks per week:** _____________

Do you drink caffeine? ☐ Yes ☐ No

Please complete the following symptom questionnaire:

Symptom	Yes	No
Constitutional		
Fever	☐	☐
Fatigue	☐	☐
Weight loss	☐	☐
Eyes/ears/throat		
Vision changes	☐	☐
Hearing changes	☐	☐
Difficulty swallowing	☐	☐
Sore throat	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐
Cardiovascular		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Blood in stool	☐	☐
Musculoskeletal		
Muscle weakness	☐	☐
Joint pain	☐	☐

Symptom	Yes	No
Neurological		
Headache	☐	☐
Seizures	☐	☐
Dizziness	☐	☐
Urinary		
Pain with urination	☐	☐
Blood in urine	☐	☐
Skin		
Rash	☐	☐
Itching	☐	☐
Skin lesions	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Metabolic		
Heat intolerance	☐	☐
Cold intolerance	☐	☐
Blood		
Easy bruising/bleeding	☐	☐
Swollen lymph node	☐	☐

Family History: Please list conditions/illness (ex. Diabetes, high blood pressure, cancer, etc.)

Father: ______________________________ Mother: ______________________________

Sister: ______________________________ Brother: ______________________________

Grandparents/other: ____

Preventative Measures:

Have you had a colonoscopy? ☐ Yes ☐ No Date: ____________

Have you had a mammogram? ☐ Yes ☐ No Date:____________

Have you had a pneumonia vaccine? ☐ Yes ☐ No Date:____________