THE IOWA CLINIC®

Medical History

General Surgery Department

Today's Date_____/_____/_______

Please use black ink – Please print

Patient Name	Sex: ☐ Male ☐ Female	Date of Birth	Occupation

Height	Weight	Marital Status	Personal Physician	Referring Physician

Reason for Today's visit:

Past Medical History

Have you ever been diagnosed with any of the following? (check all that apply)

- ☐ Diabetes
- ☐ Reaction to anesthesia
- ☐ Sleep apnea
- ☐ Blood clot
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Asthma
- ☐ Stroke
- ☐ HIV
- ☐ Dizziness after a procedure
- ☐ Ulcer
- ☐ Anemia
- ☐ Cancer/malignancy

Type____________________

- ☐ Other Medical Conditions:

____

____

____

Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, when and where? ____________________

Have you had a mammogram? ☐ Yes ☐ No If yes, when and where? ____________________

Have you ever had radiation? ☐ Yes ☐ No If yes, for what and year? ____________________

Past Surgical History

Have you had any operations/surgeries in the past? ☐ Yes ☐ No If yes, please list all prior surgeries and dates

Surgery	Date (Approximate)	Surgery	Date (Approximate)

Family History

Has anyone in your family had any of the following conditions?(Maternal/paternal parents, grandparents, aunts, uncles, 1st cousins)

Condition:	Relationship:	Age at Diagnosis
☐ Heart Disease		
☐ Diabetes		
☐ Colon Disease		
☐ Stroke		
☐ Cancer /Type:____________		

Social History

❑ Current Smoker ❑ Never a Smoker ❑ Former Smoker

in the past but you quit, when did you quit? ______________________

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks/week ______________

Do you drink caffeinated beverages? ❑ Yes ❑ No If yes, how many drinks/day ______________

Allergies

Are you allergic to any medications? ❑ Yes ❑ No If yes, which medicine? ______________

What happens? ______________________

Are you allergic to ❑ iodine ❑ contrast dye ❑ latex ❑ tape

What happens? ______________________

Have you ever had an allergic reaction to a blood transfusion? ❑ Yes ❑ No

Current Medication List

Please list all medication you are currently taking, including prescription and "over the counter"

Are you taking any blood thinners (such as aspirin, Coumadin or Plavix)? ❑ Yes ❑ No

If yes, which? ______________________

Review of Systems

Have you had any of the following problems <u>recently?</u> (please answer "Yes" or "No" to every item; do not skip):

Fever	❑ Yes	❑ No	Passage of stones or gravel in urine	❑ Yes	❑ No
Chills	❑ Yes	❑ No	Excessive thirst/fluid intake	❑ Yes	❑ No
Recent weight loss	❑ Yes	❑ No	Excessive sweating	❑ Yes	❑ No
Headaches	❑ Yes	❑ No	Easy bleeding	❑ Yes	❑ No
Chest pain or discomfort	❑ Yes	❑ No	Easy bruising tendency	❑ Yes	❑ No
Palpitations/ irregular heart beat	❑ Yes	❑ No	Diffuse joint pain	❑ Yes	❑ No
Difficulty breathing (dyspnea)	❑ Yes	❑ No	Localized swelling in both ankles	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No	Muscle aches	❑ Yes	❑ No
Chronic cough	❑ Yes	❑ No	Dizziness	❑ Yes	❑ No
Loss of appetite	❑ Yes	❑ No	Convulsions	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No	Fainting spells	❑ Yes	❑ No
Vomiting blood	❑ Yes	❑ No	Anxiety	❑ Yes	❑ No
Yellow skin or eyes (jaundice)	❑ Yes	❑ No	Depression	❑ Yes	❑ No
Blood in urine	❑ Yes	❑ No	Other		

Print Name ______________________ Date of Birth ______________