

Date: _____

REVIEW OF SYSTEMS & PAST FAMILY SOCIAL HISTORY QUESTIONNAIRE

Welcome to the Surgical Institute of South Dakota, P.C. Please fill out as much of this questionnaire as you can. Please feel free to ask for assistance if you have any questions about this form when you are taken back for your examination. *Thank you providing us with this information!*

Name: _____ Birth Date: _____ Age: _____

Home Phone: _____ Cell/Work Phone: _____

Referring doctor: _____ Doctor's address: _____

Your medical doctor: _____ Medical doctor's address: _____

Should any other doctor receive a copy of my note from today? (If yes, whom?) _____

Past Medical History: Medical conditions (when/why) _____

Operations/Surgeries: (when/for what) _____

Medications: A list of any medications you take regularly (including aspirin or vitamins) with DOSE:

Allergies: A list of all allergies including medications, iodine, anesthesia, latex, tape, etc.:

Social History: Occupation: _____ Do you live alone? Yes No

Are you married? Yes No Name of spouse: _____

How many children do you have? _____ Have you ever smoked? Yes No

How many years have you smoked? _____ Packs per day: _____

Do you currently smoke? Yes No If no, when did you stop? _____

How much alcohol do you drink in a week? _____

Family History: Check any of the following conditions that affected any of your family members, and their relationship to you. If yes, please state relationship & age family member was diagnosed.

Colon Cancer Yes No _____ Breast Cancer Yes No _____

Ovarian Cancer Yes No _____ Lung Cancer Yes No _____

Other Cancer Yes No _____ Diabetes Yes No _____

Heart Disease Yes No _____ Hypertension Yes No _____

Stroke Yes No _____ Other Yes No _____

Date: _____ Name: _____ DOB: _____ Chart # _____

PAST ILLNESSES AND REVIEW OF SYMPTOMS

Have you ever had problems with any of the following in the past? Please check (✓) Yes or No. If "yes", please explain when it started and any diagnosis or treatment you received.

Cancer	YES	NO	EXPLANATION OF PROBLEM/TREATMENT
Type: _____	_____	_____	_____
Type: _____	_____	_____	_____
Type: _____	_____	_____	_____

Constitutional Symptoms

Fever	_____	_____	_____
Loss of appetite	_____	_____	_____
Weight loss	_____	_____	_____

Cardiovascular (heart, blood vessels)

Heart beat irregularity	_____	_____	_____
Angina/chest pain	_____	_____	_____
Hardening of arteries	_____	_____	_____
Heart attack	_____	_____	_____
Stroke	_____	_____	_____
History of cardiac testing	_____	_____	_____
High blood pressure	_____	_____	_____

Respiratory (lungs, breathing)

Chronic bronchitis	_____	_____	_____
Asthma	_____	_____	_____
Emphysema	_____	_____	_____
Shortness of breath	_____	_____	_____
Cough	_____	_____	_____
Sleep Apnea	_____	_____	_____

Gastrointestinal (stomach, bowels)

Inflammatory bowel disease	_____	_____	_____
Ulcerative disease	_____	_____	_____
Bloody stools	_____	_____	_____
Nausea	_____	_____	_____
Vomiting	_____	_____	_____
Diarrhea	_____	_____	_____
Abdominal pain	_____	_____	_____
Hepatitis-known exposure to	_____	_____	_____
Hepatitis-positive testing of	_____	_____	_____
Liver disease	_____	_____	_____

Genitourinary (urinary tract, genitals)

Frequent urination	_____	_____	_____
Painful urination	_____	_____	_____
Blood in urine	_____	_____	_____
Kidney failure/disease	_____	_____	_____
Dialysis	_____	_____	_____
Chronic urinary tract infection	_____	_____	_____
Prostate disease	_____	_____	_____
History of kidney stones	_____	_____	_____

Date: _____ Information reviewed and confirmed by: _____

Date: _____ Name: _____ DOB: _____ Chart # _____

Musculoskeletal (muscle, bones)	YES	NO	EXPLANATION OF PROBLEM/TREATMENT
Muscle pain	_____	_____	_____
Muscle weakness	_____	_____	_____
Arthritis	_____	_____	_____
Joint pain	_____	_____	_____
Osteoporosis	_____	_____	_____
Integumentary (skin, breast)			
Skin rashes	_____	_____	_____
Eczema	_____	_____	_____
Psoriasis	_____	_____	_____
Breast masses	_____	_____	_____
Acne rosacea	_____	_____	_____
Tattoos	_____	_____	_____
Neurological (nerves, brain)			
Migraines	_____	_____	_____
Memory loss	_____	_____	_____
Speech loss	_____	_____	_____
Weakness in arms and legs	_____	_____	_____
Seizures	_____	_____	_____
Problems with anesthesia	_____	_____	_____
Stroke	_____	_____	_____
Endocrine (hormones, metabolism, glands)			
Diabetes	_____	_____	_____
Thyroid disease	_____	_____	_____
Weight gain	_____	_____	_____
Excessive thirst or hunger	_____	_____	_____
Excessive urination	_____	_____	_____
Excessive nervousness	_____	_____	_____
Excessive irritability	_____	_____	_____
Intolerances to heat or cold	_____	_____	_____
Hematologic/Lymphatic (blood, lymph nodes)			
Blood disorders	_____	_____	_____
Lymph node swelling	_____	_____	_____
Anemia	_____	_____	_____
Bleeding tendencies	_____	_____	_____
Allergic/Immunologic			
Seasonal allergies (hay fever)	_____	_____	_____
Sneezing	_____	_____	_____
Psychiatric			
Depression	_____	_____	_____
Anxiety	_____	_____	_____
Other	_____	_____	_____

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