

**Rappahannock Trauma and Acute Care Surgeons
Patient History Questionnaire**

This questionnaire is confidential and will be kept as part of your medical record.

Patient Name: _____ Date of Birth: _____ Age: _____
 Referring Doctor: _____
 Primary Care Physician: _____

Past Medical History: Place a mark on “yes” or “no” to indicate if you have or have had any of the following:

Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no
High blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no	Bleeding problem	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Lung disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no	AIDS/HIV	<input type="checkbox"/> yes <input type="checkbox"/> no
High cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no	Hereditary defects	<input type="checkbox"/> yes <input type="checkbox"/> no
High triglycerides	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have a pacemaker?	<input type="checkbox"/> yes <input type="checkbox"/> no
Problems with anesthesia?	<input type="checkbox"/> yes <input type="checkbox"/> no		

Any other past medical history not listed: _____

Previous trauma? yes no If yes, what year and please specify: _____

Past Surgical History: (Please write on back of sheet if additional space is needed)

Type of Operation

_____ Year: _____
 _____ Year: _____
 _____ Year: _____

Review of Systems:

Place a mark on “yes” or “no” to indicate if you **CURRENTLY** have any of the following:

Fevers	<input type="checkbox"/> yes <input type="checkbox"/> no	Voice Changes	<input type="checkbox"/> yes <input type="checkbox"/> no	Weak stream	<input type="checkbox"/> yes <input type="checkbox"/> no
Chills	<input type="checkbox"/> yes <input type="checkbox"/> no	Nose bleeds	<input type="checkbox"/> yes <input type="checkbox"/> no	Prostatitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Sweats	<input type="checkbox"/> yes <input type="checkbox"/> no	Shortness of breath	<input type="checkbox"/> yes <input type="checkbox"/> no	Syncope (fainting)	<input type="checkbox"/> yes <input type="checkbox"/> no
Weight Gain	<input type="checkbox"/> yes <input type="checkbox"/> no	Palpitations	<input type="checkbox"/> yes <input type="checkbox"/> no	Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no
Weight loss	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart burn	<input type="checkbox"/> yes <input type="checkbox"/> no	Back pains	<input type="checkbox"/> yes <input type="checkbox"/> no
Blurred vision	<input type="checkbox"/> yes <input type="checkbox"/> no	Abdominal pain	<input type="checkbox"/> yes <input type="checkbox"/> no	Leg pains	<input type="checkbox"/> yes <input type="checkbox"/> no
Worsening visual activity	<input type="checkbox"/> yes <input type="checkbox"/> no	Vomiting blood	<input type="checkbox"/> yes <input type="checkbox"/> no	Circulation problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Hearing loss	<input type="checkbox"/> yes <input type="checkbox"/> no	Spitting up blood	<input type="checkbox"/> yes <input type="checkbox"/> no	FEMALES:	
ringing in ears	<input type="checkbox"/> yes <input type="checkbox"/> no	Nausea	<input type="checkbox"/> yes <input type="checkbox"/> no	Last menstrual period:	
Skin rashes	<input type="checkbox"/> yes <input type="checkbox"/> no	Early satiety (fullness)	<input type="checkbox"/> yes <input type="checkbox"/> no	Are you pregnant?	<input type="checkbox"/> yes <input type="checkbox"/> no
Heat intolerance	<input type="checkbox"/> yes <input type="checkbox"/> no	Excessive thirst	<input type="checkbox"/> yes <input type="checkbox"/> no	# of live births:	
Cold intolerance	<input type="checkbox"/> yes <input type="checkbox"/> no	Difficulty swallowing	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you had an abortion?	<input type="checkbox"/> yes <input type="checkbox"/> no
Depression	<input type="checkbox"/> yes <input type="checkbox"/> no	Difficulty urinating	<input type="checkbox"/> yes <input type="checkbox"/> no	Last breast exam:	
Anxiety	<input type="checkbox"/> yes <input type="checkbox"/> no	Frequent urination	<input type="checkbox"/> yes <input type="checkbox"/> no	Last mammogram:	

Medications: Please list Medication, dosage, and frequency. (If additional space is needed, please write on the back.)

Medication

Dosage

Frequency

Patient Name: _____

Allergies: Please list Allergies and Reactions. (If additional space is needed, please write on the back.)

NO KNOWN DRUG ALLERGIES

Medicine

Reaction

LATEX ALLERGY? yes no

ALLERGY TO IV DYE? yes no

Family History: Place a mark next to "yes" or "no".

Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Gallbladder disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
High blood pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart attack	<input type="checkbox"/> yes	<input type="checkbox"/> no
Stroke	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no If yes, please specify:

Any other Family Medical History not mentioned:

Social History:

Occupation: _____

Do you smoke? yes no If yes, how much? _____ How long? _____

Do you drink alcohol? yes no If Yes, how much? _____ How long? _____

Do you use recreational drugs? yes no

Signature of Patient, Parent, Guardian or Personal Representative

Date

Office Use Only:

MRN: _____

Provider Signature

Date Reviewed