

**Western Wake Surgical
Patient Questionnaire**

Name: _____
 Reason for visit today: _____
 Doctor who sent you to us: _____
 Primary care doctor: _____
 Height: _____ Ft. _____ in. Weight: _____ lbs.

Past Medical History

Please check all medical problems you have had in the past:

- Abdominal Aortic Aneurysm
- Alcoholism
- Alzheimer's disease
- Anemia
- Angina
- Arthritis
- Asthma
- Blood clot in leg/lung
- Bronchitis
- Coronary Artery Disease
- Cancer
Type: _____
- Cardiac Catherization
- Cataracts
- Cirrhosis
- Colon Polyps
- Crohn's disease
- Depression
- Diabetes
- Diverticulosis/Diverticulitis
- Emphysema
- Endometriosis
- Fibromyalgia
- Glaucoma
- Gout
- Headaches
- Hearing Loss
- Heart Attack
- Heart beat irregular
- Heart murmur
- Hemorrhoids
- Hepatitis
- High cholesterol
- HIV / AIDS
- High blood pressure
- Irritable bowel syndrome
- Kidney failure
- Kidney Stones
- Liver Disease
- Mitral Valve Prolapse
- Osteoporosis
- Parkinson's Disease
- Pelvic Inflammatory disease
- Pneumonia
- Reflux
- Seizures
- Sickle cell disease
- Stroke
- Thyroid Problems
- Transfusions
- Transplant
- Tuberculosis
- Ulcerative Colitis
- Ulcer
- Vision Loss
- Other _____

Past Surgical History

Please list all operations you have had in the past:

None

Medications

Please list all medications you are currently taking(include dosage):

Allergies:

Please list all medicines you are allergic to or have a reaction to:

SHELLFISH

LATEX

NONE-please check box if you have no allergies/reactions

Family Medical History

Please list all medical problems that run in your family:

Have you recently had any of the following symptoms/ Check all that apply.

<u>General</u>	Yes	No
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Fever(Currently)	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
<u>Eyes</u>		
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ears/Nose/Throat</u>		
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
<u>Lungs</u>		
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>
Recent cold	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Coughing phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
<u>Heart</u>		
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in feet	<input type="checkbox"/>	<input type="checkbox"/>
<u>Stomach/Intestines</u>		
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Change in stools	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
<u>Kidneys/Genitals</u>		
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
<u>Muscles/Bones</u>		
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neurology</u>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
<u>Skin</u>		
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
<u>Breast</u>		
Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>
Breast pain	<input type="checkbox"/>	<input type="checkbox"/>
<u>Psychiatric</u>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
<u>Blood</u>		
Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged lymph node	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		