East Hawaii Health
134 Pu`uhonu
General Surgery

Patient Name: _____ Birthdate: _____

SUPPLEMENTAL MEDICAL QUESTIONAIRE

What is your reason for seeing the surgeon? _____

Have you travelled outside the state in the past 30 days? [ ] Yes [ ] No

Have you had a pneumococcal vaccine? [ ] Yes [ ] No

Are you in pain? [ ] Yes [ ] No If yes, where? _____

Quality of pain: [ ] Cramping [ ] Squeezing [ ] Burning [ ] Stinging [ ] Stabbing [ ] Other: _____

On a scale of 1 (weak) to 10 (extreme), how severe is your pain? _____ How long does it usually last? _____

Have you fallen in the past 12 months? [ ] Yes [ ] No

Are you a smoker? [ ] Yes [ ] No [ ] Former

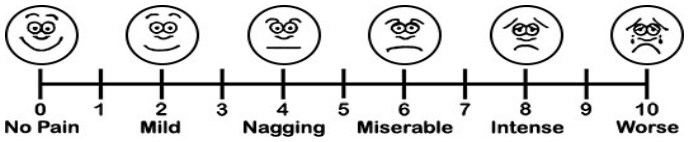
If Yes, how many years have you smoked? _____

If Former, how many years did you smoke? _____

Thoughts of suicide? [ ] Yes [ ] No

Are you frightened at home? [ ] Yes [ ] No

Rate your pain: Circle the number that best describes your pain right now



Review of Systems

Please check boxes to indicate if you have any of the following problems:

CARIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure (Hypertension)
- ☐ Heart Attack
  If yes, when?
  _____
- ☐ Heart Failure
- ☐ Palpitations/Irregular Heart Beat
- ☐ Valve Disease / Rheumatic Fever

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sleep Apnea

NEUROLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Stroke/TIA
  If Yes, when?
  _____
- ☐ Seizure
- ☐ Other Mental Illness:
  _____

RENAL
- ☐ Frequent Urinary Tract Infections
- ☐ Kidney Stones
  If Yes, when?
  _____
- ☐ Problems with Urinating
- ☐ Renal/Kidney Insufficiency
  If Yes, are you on dialysis?
  [ ] Yes [ ] No

HEMOTOLOGY
- ☐ Anemia
  History of Blood Transfusions?
  [ ] Yes [ ] No
- ☐ Blood Clots, DVT or Pulmonary Embolism?
  If Yes, when?
  _____

MUSKULOSKELTAL
- ☐ Arthritis
- ☐ Back Pain
- ☐ Difficulty Walking
- ☐ Joint Pain

ENDOCRINE
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

GASTROINTESTINAL
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ History of Stomach Ulcers
- ☐ Nausea
- ☐ Regurgitation of Food
- ☐ Vomiting

GENERAL
- ☐ Cancer
  If Yes, what type?
  _____
- ☐ Fever
- ☐ Recent Weight Loss

Supplemental Family Medical History

Please select any known family history of health problems:

	Diabetes	Heart Disease	Breast Cancer	Colon Cancer	Other Cancer:
Father	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	_____
Brother	☐	☐	☐	☐	_____
Sister	☐	☐	☐	☐	_____
Maternal Grandfather	☐	☐	☐	☐	_____
Maternal Grandmother	☐	☐	☐	☐	_____
Paternal Grandfather	☐	☐	☐	☐	_____
Paternal Grandmother	☐	☐	☐	☐	_____
Daughter	☐	☐	☐	☐	_____
Son	☐	☐	☐	☐	_____

Patient Signature: *X*_____ Date: _____/ _____/ _____

Official use only: MRN#: _____ Account #: _____

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Surgeries: ***(Please note any past surgeries, or select "NONE")***

[ ] None

_____ Year: _____ _____ Year: _____

_____ Year: _____ _____ Year: _____

_____ Year: _____ _____ Year: _____

Medications: ***(Please list medications and dosage, or select "NONE")*** **Dosage:**

[ ] None

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to: [ ] Tape [ ] Latex [ ] Iodine

Medication Allergies: ***(Please list medications and dosage, or select "NONE")***

[ ] None

_____

_____

Social History:

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Number of children: _____

Occupational Status: [ ] Disabled [ ] Retired [ ] Unemployed [ ] Employed

Occupation: _____

Alcohol Intake: [ ] Never [ ] 1 Drink Daily [ ] 2+ Drinks Daily [ ] Few Drinks a Week

[ ] Few Drink a Month [ ] Occasional (*Holidays / Special Occasions*)

*Preferred Pharmacy:

Name: _____

Location: _____

Is there anything else that you would like your surgeon to know?

_____

_____

Patient Signature: *X*_____ Date: _____/ _____/ _____