NorthStar Surgery
Specialists, P.A.

12414 Alderbrook Drive
Suite 101
Austin, TX 78758
Phone: (512) 491-6542
Fax: (512) 491-0161

Medical History Form

Patient Name: ____
First Middle Last

Date of Birth: ____ / ____ / ______ Sex ☐ M ☐ F Height: ________ Weight: ________

Primary Care Physician: ____________________ Referring Physician: ____________________

Address ____________________ Address ____________________

City/State/Zip ____________________ City/State/Zip ____________________

Chief Complaint / Purpose of Visit: ______________________________________

Medical History - Please list all Current and Past Medical Conditions: ☐ None

☐ Heart Disease
☐ Previous Heart Attack / Chest Pain
☐ Congestive Heart Failure
☐ Heart Valve Disorders
☐ Heart Rhythm Problems
☐ High Blood Pressure
☐ High Cholesterol / Lipids
☐ History of Stroke
☐ Diabetes
☐ Peripheral (Leg) Vascular Disease
☐ Epilepsy / History of Seizures
☐ Arthritis
☐ Anemia
☐ Stomach Ulcer
☐ Clotting / Bleeding Disorder
Type: ____________________

☐ COPD/Emphysema/Bronchitis
☐ Asthma
☐ Other Lung Disease
Type: ________________
☐ Cancer
Type: ________________
☐ Gall Bladder Disease
Type: ________________
☐ Bowel Disease
Type: ________________
☐ Hepatitis / Liver Disease
Type: ________________
☐ Kidney / Bladder Disease
Type: ________________
☐ Thyroid Disease
Type: ________________

Other:
____
____
____
____
____
____
____

Please list any pertinent descriptions, if needed, of any above conditions checked:

____

____

Surgical History - Please list Previous Operations and the year when they were performed: ☐ None

Procedure	Year	Procedure	Year	Procedure	Year
☐ Gallbladder (Cholecystectomy)	_____	☐ Coronary Artery Bypass	_____	☐ Thyroid	_____
☐ Appendix (Appendectomy)	_____	☐ Other Heart Surgery	_____	☐ Breast Biopsy/Mastectomy	_____
☐ Hernia Repair (any)	_____	☐ Lung Surgery	_____	☐ Tonsillectomy	_____
☐ Stomach/Bowel Surgery	_____	☐ Joint/Back Surgery	_____	☐ Plastic Surgery	_____
☐ Rectal/Hemorrhoid	_____	☐ Hysterectomy/C-Section	_____	☐ Skin surgery (Mole Removal, Graft, etc.)	_____

☐ Other ____

Medications - Please list all medications you are taking, including over-the-counter and herbal: ☐ None

____

____

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Allergies – Please list any allergies to medications below: ☐ None ☐ Latex

____

____

Social History:

Marital Status:	Do you have children?	Do you smoke or chew tobacco?	
☐ Single	☐ Yes	☐ No	Packs per day: _______
☐ Married	☐ No	☐ Chew	Number of years: _______
☐ Divorced	How many? _________	☐ Smoke	Have you tried to quit? ☐ Yes ☐ No
☐ Widowed	Ages _______________		

Do you use illicit drugs? ☐ Yes ☐ No
Type and Frequency ___________________
____

Do you drink alcohol? ☐ Yes ☐ No
Type and Frequency ______________________________
____

Occupation ____

Family History: Does anyone in your family have any of the following? If so, list your relation to them:

☐	Breast Cancer	_______________	☐	Stroke	_______________
☐	Colon Cancer	_______________	☐	Epilepsy / Seizures	_______________
☐	Ovarian/Uterine Cancer	_______________	☐	GallBladder Disease	_______________
☐	Melanoma	_______________	☐	Bleeding / Clotting History	_______________
☐	Prostate Cancer	_______________	☐	Diabetes	_______________
☐	Lung Cancer	_______________	☐	Heart Disease	_______________
☐	Pancreatic Cancer	_______________	☐	Lung Disease	_______________
☐	Lymphoma / Leukemia	_______________	☐	High Blood Pressure	_______________
☐	Thyroid Cancer	_______________	☐	High Lipids / Cholesterol	_______________
☐	Skin Cancer	_______________	☐	Other _______________	_______________
☐	Other Cancer (Type and Family Member)	_______________	☐	Other _______________	_______________

Hospital preference, if needed: ☐ St. David's ☐ Seton

Will you absolutely refuse blood transfusions under any circumstances? ☐ Yes ☐ No

X-Rays / Labwork done: ☐ None
☐ Yes – Type and Location: ____
____

Who is accompanying you today? ____

If you are under 18 years old, what school grade are you in? _________

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Are your immunizations up to date? ☐ Yes ☐ No

Have you ever been treated by a physician for any of the following? Please check the box if "Yes."

Please explain any "Yes" answers at the bottom of this page and write the year you were diagnosed and/or treated.

General:
- ☐ Weight Loss ________lbs
- ☐ Weight Gain ________lbs
- ☐ Last Tetanus shot (year) _______

Eyes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Recent vision changes

Cardiovascular
- ☐ Chest pain
- ☐ Irregular Heartbeat
- ☐ Shortness of breath
- ☐ Feet / leg swelling
- ☐ Varicose veins

Women Only:

Last menstrual period started _______
- ☐ Number of pregnancies _______
- ☐ Number of deliveries _______
- ☐ Last pap smear (date)
- ☐ Menstrual irregularities
- ☐ Menopause, age? _______
- ☐ Vaginal discharge
- ☐ Venereal disease

Men Only
- ☐ Prostate disease
- ☐ Testicular lumps, pain
- ☐ Venereal disease

Gastrointestinal
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Last Colonoscopy (year) _______
- ☐ Last Flex. Sig. (year) _______
- ☐ Last stool occult blood test (year) _______

Urinary
- ☐ Painful urination
- ☐ Slow/frequent urination
- ☐ Infections
- ☐ Blood in urine
- ☐ Kidney stones

Breast

Last mammogram (date) _______
- ☐ Monthly self exams
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Pains

Hematologic/Lymphatic
- ☐ Easy bleeding or bruising
- ☐ Anemia

Blood transfusion (year) _______

Musculoskeletal
- ☐ Fractures/dislocations
- ☐ Muscle pain/cramps

Neurologic
- ☐ Headaches
- ☐ Weakness
- ☐ Dizziness
- ☐ Numbness / tingling

Psychiatric
- ☐ Depression
- ☐ Trouble sleeping
- ☐ Schizophrenia
- ☐ Alcohol dependency
- ☐ Drug dependency

Respiratory
- ☐ Cough
- ☐ Trouble breathing
- ☐ Wheezing
- ☐ Pneumonia

Ears/Nose/Mouth/Throat
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Gum problems
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Trouble swallowing

Immunologic
- ☐ HIV / AIDS
- ☐ Hepatitis (A, B, or C?)

Skin
- ☐ Rashes / dermatitis
- ☐ Changes in moles

Please explain any "Yes" answers below:

____

____

____

____