NorthStar Surgery
Specialists, P.A.
2217 Park Bend Drive, Suite 220
Austin, TX 78758
Phone: 512-491-6542 ¦ Fax: 512-491-0161

Medical History Form

Patient Name: _____ Today's Date: _____
First Middle Last

Date of Birth: ____ / ____ / _____ Sex ☐ M ☐ F ☐ Other 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:
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Do you have children?
☐ Yes
☐ No
How many? _____
Ages _____

Do you smoke or chew tobacco?
☐ Never
☐ Chew
☐ Smoke
☐ Former Smoker → Date Quit _____
Packs per day: _____
Number of years: _____
Have you tried to quit? ☐ Yes ☐ No

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	_____	☐ Hemorrhoids	_____
☐ Other Cancer (Type and Family Member)	_____	☐ Other _____	_____

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

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

Are your immunizations up to date? ☐ Yes ☐ No

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Are you currently being 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.

General
- ☐ Weight Loss _____lbs
- ☐ Weight Gain _____lbs
- ☐ Fever/Chills

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

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

Women Only:

Last pap smear _____
- ☐ Number of pregnancies _____
- ☐ Number of deliveries _____
- ☐ Venereal disease
- ☐ Menstrual irregularities
- ☐ Menopause, age? _____
- ☐ Vaginal discharge

Men Only:

Last Prostate Exam (YR) _____
Last PSA Test (YR) _____
- ☐ Prostate disease
- ☐ Testicular lumps, pain
- ☐ Venereal disease

Gastrointestinal

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

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:

_____

_____

_____

_____