ANDOVER SURGICAL ASSOCIATES
HEALTH HISTORY

NAME ______________________________________ TODAY'S DATE ____________

AGE _____ DATE OF BIRTH _____ REFERRING PHYSICIAN ____________________

PRIMARY CARE PHYSICIAN _______________ Address ________________________

HEIGHT: _______________ **WEIGHT:** ____________________

CHIEF COMPLAINT: For what problem were you sent today ?

____

MEDICAL HISTORY:
ALLERGIES: To medications, Latex, IV Contrast, Shellfish, Foods

____

MEDICATIONS: List current medications that you are taking

Name	Dosage	Frequency	Name	Dosage	Frequency

Do you take "**blood thinners**" i.e., aspirin, anti-inflammatories, Coumadin? ____ Last dose ____
Do you have a history of bleeding disorder? ______________________________

PAST/CURRENT MEDICAL PROBLEMS

______________________ ______________________

______________________ ______________________

Please check if you have had any of these problems:

Asthma	☐	Glaucoma	☐	Mitral Valve Prolapse
Atrial Fibrillation	☐	Heart Disease	☐	Thyroid Disease
Diabetes	☐	Hepatitis	☐	Ulcer
Emphysema	☐	High Blood Pressure	☐	Blood Clots

PREVIOUS SURGERIES (Date and Type)

______________________ ______________________

______________________ ______________________

GYNECOLOGIC HISTORY
Are you pregnant now? _______________ Last Menstrual Period: _______________

Pregnancy: Date and type of delivery

____

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FAMILY HISTORY **(Check any that pertain to an immediate relative and indicate relationship to you and that person's age at his/her diagnosis)**

Colon Cancer ____________________ Colon Polyps ____________________

Colitis ____________________ Crohn's Disease____________________

Breast Cancer ____________________ Ovarian Cancer ____________________

Heart Disease ____________________ Problems with Anesthesia ______________

SOCIAL HISTORY Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Alcohol Use: How much? ____________________

Tobacco Use How much? ____________________

Drug Use: Type/ how much? ____________________

Occupation: ____________________

REVIEW OF SYSTEMS **Have you commonly or recently had any of these symptoms? Please check those that apply**

Constitutional Fever ____ Chills _____ Dizziness ______ Night Sweats ___

Eyes Double Vision ____ Other ______

Ears/Nose/Mouth/Throat Pain ____ Pressure _____ Deafness ____ Hoarseness ___

Cardiovascular Chest Pain ________ Chest Pressure _________

Irregular Heart Beat _______ Shortness of breath ________

Palpitations __________

Respiratory Chronic Cough ______ Shortness of Breath

Gastrointestinal Abdominal Pain _____ Vomiting _____ Heartburn ________

Change in bowel habits __ Bloody Stools __ Loss of appetite

Genitourinary Urinary Tract Infections _______ Kidney Stones _________

Musculoskeletal Joint Pain ____ Swelling ____ Weakness ____ Stiffness ___

Neurological Weakness _____ Numbness _____ Speech ___ Memory ___

Headaches __________

Psychiatric Depression Anxiety Other