



Valley Surgical Specialists

A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTE HEALTH FOUNDATION

Valley Surgical Specialists Medical Group
BSV Medical Pavilion
782 Medical Center Drive East #101
Clovis, CA 93611
(559) 256-4111

Valley Surgical Specialist Medical Group Medical HX Form

A Member Of Community Foundation Medical Group & Sante Health Foundation

Name: D.O.B: Date: MR#:

Referring MD: Primary Care Physician:

Reason you are seeing the doctor today?

MEDICAL HISTORY: (please check)

Cardiac disease Lung disease Thyroid disease
High blood pressure Diabetes Other:
Kidney disease Liver disease Other:

CURRENT MEDICATIONS AND DOSAGES: (including aspirin, blood thinners, and any herbal medications) or provide list

1. 4. 7.
2. 5. 8.
3. 6. 9.

MEDICATION ALLERGIES: (Penicillin, Sulfa, Morphine, Demerol, etc.) Latex Allergy: Yes No

PAST SURGERIES: (include approximate year if known)

1. 4. 7.
2. 5. 8.
3. 6. 9.

FAMILY HISTORY:

Number of Brothers: Number of Sisters:
Cardiac Disease: Yes No Diabetes: Yes No High Blood Pressure: Yes No
Whom: Whom: Whom:
Cancer of: Breast Ovarian Colon Prostate N/A Other type of cancer:
Relation & Age:

SOCIAL HISTORY:

Do you smoke? Yes No How many years? Number of packs per day? When did you quit?
Do you drink alcohol? Yes No Frequently Seldom Socially
Profession: Retired Student

REVIEW OF SYSTEMS: Circle YES or NO

General

Fever / chills	Yes	No
Night sweats	Yes	No
Fatigue	Yes	No
Weight changes	Yes	No

Skin

Cancer	Yes	No
Rash	Yes	No
Change in mole	Yes	No
Persistent itching	Yes	No
Bruise easily	Yes	No

HEENT

Glasses	Yes	No
Dizziness	Yes	No
Vertigo	Yes	No
Hearing Loss	Yes	No
Headaches	Yes	No

Cardiac

Chest pain / Angina	Yes	No
Palpitations	Yes	No
High blood pressure	Yes	No
Edema	Yes	No
Name of Cardiologist: _____		

Respiratory

Frequent cough	Yes	No
Asthma	Yes	No
Shortness of breath	Yes	No
Tuberculosis	Yes	No

Gastrointestinal

Heartburn	Yes	No
Nausea / vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Change in stool	Yes	No
Diverticulitis	Yes	No
Irritable bowel disease	Yes	No
Last Colonoscopy: _____		

Urinary

Urine retention	Yes	No
Incontinence	Yes	No
Frequency	Yes	No
Blood in urine	Yes	No

Hematologic

Prior blood transfusion	Yes	No
Blood clotting problem	Yes	No
Excessive bleeding w/ injuries	Yes	No

Neurological

Seizures	Yes	No
Stroke	Yes	No
Tremor	Yes	No
Fainting	Yes	No

Psychological

Depression	Yes	No
Anxiety	Yes	No
Insomnia	Yes	No

Musculoskeletal

Arthritis	Yes	No
Back pain	Yes	No
Fibromyalgia	Yes	No

Endocrine

Too hot / too cold	Yes	No
Excessive weight gain / loss	Yes	No
Dry skin	Yes	No
Diabetes	Yes	No

Allergy

See 1st page

Cancer

Type: _____
 Oncologist: _____
 Chemotherapy _____
 Radiation Therapy _____

FOR BREAST PATIENTS / WOMEN ONLY:

Number of pregnancies _____ Live births _____ Age at 1st pregnancy _____
 Age at 1st period _____ Date of last period _____ Date of last mammogram _____ Date of last PAP _____
 Did you breast feed _____ How long _____ Bra cup size _____
 Have you used hormone replacement or birth control pills/injections _____ For how long? _____
 Do you practice routine breast self-examination? Yes No
 Family History of Breast Cancer: Relation/Age _____ Relation/Age _____
 Family History of Ovarian Cancer: Relation/Age _____ Relation/Age _____

MD Signature: _____ Date: _____