



New Patient Health History

Name: _____

Sentara Surgery Specialists

Date: _____ MRN: _____

Sentara MedicalGroup

Today's Complaint: _____

Please list any medical problems you have:

Please list any surgeries you have had:

Please list any medications (and dosages) that you currently take:

Please list allergies to any medications you have:

Did you ever smoke? No Yes

If yes, how many packs per day? _____ Year started _____ Year quit _____

Do you drink alcohol? No Yes

If yes, on average _____ (how many) drinks per _____ month (circle)

Does anyone in your family have? (Please circle)

- Breast Cancer Colon Cancer Ovarian Cancer
High Blood Pressure Diabetes Heart Attack Stroke

Name: _____

Date: _____ MRN: _____

 Sentara Surgery Specialists
 Sentara MedicalGroup


Fevers
Chills
Night Sweats
Loss of appetite
Tiredness
Weakness
Weight Loss
Vision Problems
Eye pain
Double vision
Headaches
Ear pain
Ringling in the ears
Loss of hearing
Runny nose
Sinus trouble
Nosebleeds
Sore throat
Hoarseness
Chest pain
Shortness of breath lying down
Shortness of breath at night
Leg swelling
Palpitations
Fainting spells

Coughing
Shortness of breath
Excessive sputum
Coughing up blood
Nausea
Vomiting
Diarrhea
Constipation
Change in bowel habits
Trouble swallowing
Black bowel movements
Use of antacids
Painful urination
Trouble starting urination
Dribbling or incontinence
Discharge
Sexual dysfunction
Lumps in groin
Arthritis
Gout
Joint swelling
Muscle cramps
Weakness
Muscle pain
Muscle stiffness
Rashes

New moles
Changing mole
Memory loss
Paralysis
Tingling in fingers or toes
Seizures
Fainting
Tremors
Dizziness
Depression
Crying spells
Anxiety
Cold intolerance
Heat intolerance
Excessive hunger
Excessive urination
Weight change
Prolonged bleeding
Easy bruising
Swollen lymph nodes
Hayfever
Food allergies
Frequent infections