KAISER PERMANENTE®

The Permanente Medical Group, Inc.

MR#: _____

Name: _____

IMPRINT AREA

SURGICAL ADMISSIONS HISTORY QUESTIONNAIRE

Please complete this form as carefully as you can. It will be made part of your medical record and will, of course, be confidential.

DATE: _____ FULL NAME: _____
(FIRST / MIDDLE / LAST)

Medical Record Number: _____ Sex: ☐ M ☐ F Birth Date: _____ Age: _____

Your Address: _____
(STREET / CITY / STATE / ZIP CODE)

Telephone: Work: _____ Home: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Work Telephone: _____

Person you wish us to contact, if not above: _____

Phone: _____

CHIEF COMPLAINT:

1. What is the chief reason that you are consulting the surgeon? _____

2. When did the problem first start? _____

3. If an injury, is it work related? _____

PAST MEDICAL HISTORY

CHILDHOOD

4. Did you have the usual childhood diseases, such as measles, mumps, chicken pox? _____

5. Did you have unusual childhood diseases, such as rheumatic fever, heart disease, leukemia, kidney disease,hormone disorder, tumors? Circle and explain. _____

6. Do you bleed excessively or easily, such as after tooth extractions or accidents? ☐ Yes ☐ No

   Have you ever required transfusion? ☐ Yes ☐ No

   If yes, when? _____ About how many? _____

PAST MEDICAL HISTORY (continued)

ADULT ILLNESSES

7. Please list medical diseases for which you are now being treated, or for which you have been admitted to the hospital:

	DATE OF ONSET OR DURATION
☐ High blood pressure	
☐ Diabetes	
☐ Heart attack	
☐ Heart failure	
☐ Stroke	
☐ Vascular (blood vessel) Dis.	
☐ Tuberculosis	
☐ Hepatitis	
☐ Other: Explain	

8. **FEMALES**
   a. Pregnancies, how many? _____
   b. Deliveries, how many? _____
   c. Miscarriages or abortions ☐ Yes ☐ No How many? _____
   d. Caesarean Sections, how many? _____
   e. Complications of pregnancy? _____
   f. Could you be pregnant now? ☐ Yes ☐ No
   g. Date of last normal period? _____
9. **OPERATIONS** with dates, and hospital if known: _____
10. **MEDICATIONS**: Dose and how often taken: _____

ALLERGIES TO MEDICATIONS

FAMILY HISTORY

			LIVING		AGE	CHIEF MEDICAL DISEASES
11.	Parents:	Mother	☐ Yes	☐ No	_____	_____
		Father	☐ Yes	☐ No	_____	_____
12.	Siblings:	Brother	☐ Yes	☐ No	_____	_____
		Brother	☐ Yes	☐ No	_____	_____
		Brother	☐ Yes	☐ No	_____	_____
		Sister	☐ Yes	☐ No	_____	_____
		Sister	☐ Yes	☐ No	_____	_____
		Sister	☐ Yes	☐ No	_____	_____

13. Children

	BIRTH WEIGHT	LIVING		AGE	CHIEF MEDICAL DISEASES
Male	_____	☐ Yes	☐ No	_____	_____
Male	_____	☐ Yes	☐ No	_____	_____
Male	_____	☐ Yes	☐ No	_____	_____
Female	_____	☐ Yes	☐ No	_____	_____
Female	_____	☐ Yes	☐ No	_____	_____
Female	_____	☐ Yes	☐ No	_____	_____

14. Circle disease(s) that tend to run in the family:
Diabetes, high blood pressure, heart attacks, strokes, cancer, bleeding disorders, tuberculosis, others:

_____

_____

_____

SOCIAL HISTORY

15. Do you smoke? ☐ Yes ☐ No Cigarettes? ☐ Yes ☐ No Packs per day? _____ How long? _____

Cigar? ☐ Yes ☐ No Pipe? ☐ Yes ☐ No When will you quit? _____

Have your ever smoked? _____ How much? _____ When did you stop? _____

16. Do you drink alcohol? ☐ Yes ☐ No Type? _____

How much? _____ How often? _____

17. What type of work do you do, or have you done most of your life? _____

_____

18. Have you traveled out of the country? ☐ Yes ☐ No Where? _____

_____

When? _____

19. Are you single? ☐ Yes ☐ No Married? ☐ Yes ☐ No Divorced? ☐ Yes ☐ No

REVIEW OF SYSTEMS

(If yes to following questions, when in recent past? How often?

CENTRAL NERVOUS SYSTEM	**YES**	**NO**
20. Do you have seizures?	☐	☐
Severe headaches?	☐	☐
21. Temporary changes in vision or hearing?	☐	☐
22. Any temporary loss of strength or sensation on one side?	☐	☐

CARDIOVASCULAR (Check or Explain)

23. Do you have chest pain, chest tightness, or angina on exertion?	☐	☐
At rest?	☐	☐
Duration? _____		
24. Chronic ankle swelling?	☐	☐
25. Can you sleep flat in bed?	☐	☐
26. Do you wake up at night short of breath?	☐	☐
27. Do you have frequent dizzy or fainting spells?	☐	☐

RESPIRATORY

28. Do you get short of breath on exertion?	☐	☐
29. Can you walk two flights of stairs without significant discomfort?	☐	☐
30. Do you have frequent yellow or green sputum?	☐	☐
31. Has there been any change in your voice recently?	☐	☐
32. Do you have frequent or chronic chest pain?	☐	☐
33. Do you cough up blood?	☐	☐
34. Have you ever had phlebitis, or blood clots in your legs?	☐	☐

GASTROINTESTINAL

35. Have you lost or gained weight over the last several months?	☐	☐
How much? _____		
36. Frequent nausea, vomiting, diarrhea, or constipation? _____		
37. Change in bowel habits or stool size?	☐	☐
38. Black tarry stools?	☐	☐
Blood in stools?	☐	☐
39. Hemorrhoids (piles)?	☐	☐
Hernias? (ruptures)	☐	☐
40. Peptic ulcer disease?	☐	☐
41. Have your ever vomited blood?	☐	☐

GENITOURINARY

42. Cloudy urine?	☐	☐
Blood in urine?	☐	☐
Burn on urination?	☐	☐
43. History of stones?	☐	☐
Do you get up at night several times to urinate?	☐	☐
44. For men, do you have difficulty initiating urination?	☐	☐