GENERAL & VASCULAR SURGEONS OF BUTLER COUNTY, INC
25 OFFICE PARK DRIVE HAMILTON OH 45013
(513) 844-1000 FAX (513) 896-3727
E-MAIL: gvsurgeons@hotmail.com

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Personal Physician:	**Height:** **Weight:**

Your Present Medical Problem (nature and duration):

PERSONAL HEALTH HISTORY	
Date of last physical exam:	**Dr.**
Date of last chest x-ray:	**Date of last EKG:**
Current Medications/Dose	
List any medical problems that other doctors have diagnosed or any serious injuries or accidents you have had in the past	

Surgeries		
Year	Type of Surgery (eg. gallbladder or appendix removed)	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Are you presently taking any of the following medications? If yes, please give name and dosage.		
Aspirin/Bufferin/Anacin:	Strength:	Frequency Taken:
Blood Thinning Medication:	Strength:	Frequency Taken:
Birth Control Pills:	Strength:	Frequency Taken:
****If you are on Coumadin – please discuss this with the Dr. prior to surgery****		
Allergies to medications		
Name the Drug	Reaction You Had	
Do you have a latex allergy? ☐ Yes ☐ No		

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol or beer?				☐ Yes	☐ No
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	If so, please list all drugs:					

FAMILY HEALTH HISTORY

Please list any blood relative who has had any of the following (please give relationship and details)
Birth Defects:
Bleeding Tendency:
Breast Cancer:
Colon Cancer:
Other Cancer:
Congenital Heart Disease:
Diabetes:
Heart Attack/Heart Disease:
High Blood Pressure:
High Fevers with Surgery:
Stroke:
Other:

MEDICAL HISTORY

PLEASE INDICATE IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

(Please give date of occurrence)

Stroke	☐ Yes	☐ No
Migraine	☐ Yes	☐ No
Epilepsy or Convulsions	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Chest Pains, Angina	☐ Yes	☐ No
Chest Palpitations or Fast or Irregular Heart Beat	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Bronchitis or Chronic Cough	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Other Lung Problems (please specify)	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Rectal Bleeding	☐ Yes	☐ No
Colon Polyps	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Heavy Skin Scarring	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Bladder Infection	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Low Blood Sugar	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Bleeding Tendency	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

Back Pain or Injury	☐ Yes	☐ No
MEDICAL HISTORY (CONTINUED)		
Sciatica	☐ Yes	☐ No
AIDS	☐ Yes	☐ No
Other (please specify):	☐ Yes	☐ No

WOMEN ONLY

Date of last menstruation:		
Period every _____ days		
Number of pregnancies _____ Number of live births _____ Children's Ages _____ _____ _____ _____ _____ _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
IF YOU THINK YOU MAY BE PREGNANT, PLEASE LET YOUR PHYSICIAN KNOW.		
THIS IS IMPORTANT BEFORE WE ORDER ANY X-RAYS OR PERFORM ANY SURGICAL PROCEDURES.		
Do you have or have you had:		
Breast lumps?	☐ Yes	☐ No
Breast biopsies?	☐ Yes	☐ No
Other breast surgery?	☐ Yes	☐ No
Diagnosis of breast cancer?	☐ Yes	☐ No
Nipple Discharge?	☐ Yes	☐ No
Painful or tender breasts?	☐ Yes	☐ No
Blood relatives with breast cancer? (please indicate relationship)	☐ Yes	☐ No

MEDICAL HISTORY

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(PLEASE GIVE DATE OF OCCURRENCE)

Stroke	☐ Yes	☐ No	Back Pain or Injury	☐ Yes	☐ No
Migraine	☐ Yes	☐ No	Sciatica	☐ Yes	☐ No
Epilepsy or Convulsions	☐ Yes	☐ No	AIDS	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Other (please specify):	☐ Yes	☐ No
Chest Pains, Angina	☐ Yes	☐ No			
Chest Palpitations or Fast or Irregular Heart Beat	☐ Yes	☐ No			
Heart Murmur	☐ Yes	☐ No			
Congenital Heart Disease	☐ Yes	☐ No			
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