Memorial Hermann Medical Group
New Patient Medical History-General Surgery

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Email: _____

Reason for your visit: _____

How did you hear about us? _____

SPECIALISTS

Please list any other doctors you see.	Specialty

FAMILY MEDICAL HISTORY

Please mark any conditions in your family.

CONDITION	FATHER	MOTHER	BROTHER	SISTER	OTHER
Anesthesia Related Complications					
Blood/clotting disorder					
Cancer (what kind?)					
Diabetes					
Dementia					
Depression					
High blood pressure					
High Cholesterol					
Kidney disease					
Stroke					
Other					

PAST MEDICAL HISTORY

Please mark any conditions that apply to you.

- ☐ Anxiety
- ☐ Asthma
- ☐ Blood/clotting disorder
- ☐ Cancer: _____
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema (COPD)
- ☐ Heart attack (what age?) _____
- ☐ Heart disease (blocked arteries)
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Obstructive Sleep Apnea
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other: _____
  _____

PROCEDURE HISTORY

Please list any surgeries you've had.	Date

HEALTH MAINTENANCE

Have you had these tests?	If Yes, please list date (month/day/year) and results.	No
Bone Density Screening		
Colorectal Cancer Screening		
o Colonoscopy		
o Fecal immunochemical test (FIT-DNA) (Ex: Cologuard)		
o Fecal occult blood test (FOBT) (Ex: Hemoccult Sensa)		
o Other - List name of test		
Diabetic Eye Exam		
Mammogram		
Pap Smear		

SOCIAL HISTORY

Tobacco Use: ☐ Current every day ☐ Current some days ☐ Former ☐ Never

Type (if applicable): _____

Tobacco Exposure: ☐ None ☐ At Work ☐ At Home

If you're a current or past smoker, have you smoked in the last year? ☐ Yes ☐ No

Alcohol Use: ☐ Current ☐ Past ☐ Never

Type (if applicable): ☐ Beer ☐ Wine ☐ Liquor

How often: 1-2x/year 1-2x/month 1-2x/week 3-5x/week daily 2x/day

Substance Use: ☐ Current ☐ Past ☐ Never

Type (if applicable): _____

Exercise: ☐ Light Exercise ☐ Moderate Exercise ☐ Vigorous/High Intensity Exercise

If yes, how many days per week? _____

If yes, how many minutes per session? _____

Occupation: _____ ☐ Student ☐ Retired

Have you ever been pregnant? ☐ N/A ☐ No ☐ Yes

If yes, list pregnancies here:

DATE/YEAR	WEEKS AT BIRTH	DELIVERY: VAGINAL, CESAREAN, PREGNANCY LOSS, ETC	CHILD SEX

Did you have any complications during your pregnancies? ☐ N/A ☐ No ☐ Yes

If yes, please describe: _____

_____

MEDICATIONS

☐ **I am not taking any medications.**

☐ **I brought a list of my medications from home. [You do not need to write down your medications if you brought a complete list].**

List all medications prior to assessment. Include over-the-counter, alternative medications, herbals and prescriptions.

MEDICATION NAME	STRENGTH	NUMBER OF PILLS AT ONE TIME?	HOW MANY TIMES A DAY?	PRESCRIBER	TAKING AS PRESCRIBED?
Example: *Tylenol*	*100mg*	*1*	*2*	*Dr. Smith*	☒ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Blood Thinners: circle if you are taking:

Plavix/Clopidogrel, Coumadin/Warfarin, Aspirin 81/325, Eliquis/Apixaban, Brilinta/Ticagrelor, Enoxaparin/Lovenex,

Persantin/Dipyridamole, Ticlid/Ticlopidine, Other:_____

Local Pharmacy: _____ Phone Number: _____

Mail Order Pharmacy: _____ Phone Number: _____

ALLERGIES

☐ **No Known Allergies**

MEDICATION / FOOD / ENVIRONMENTAL	REACTION	SEVERITY
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

I have completed the above to the best of my knowledge.

Patient / Guardian Signature **Print Name** **Relationship to patient** **Date**

MEMORIAL HERMANN

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