Parkway General Surgeons/Parkway Surgical Center
PATIENT HEALTH STATUS

Name ______________________________ Date of Birth ______________ Date ______________
Referring Physician ______________________ Primary Care Physician ______________________
Reason for Visit ____

PLEASE MAKE SURE THAT **ALL BOXES** ARE CHECKED EITHER NO or YES

HEAD/EYES/NOSE/THROAT	**YES**	**NO**	**Comments**
Hearing Loss			
Vision Loss			
Glaucoma			
Sinus Problems			
Seasonal allergies			
TMJ disease/problems			
NEUROLOGICAL			
Headaches or Migraines			
Seizures- Last One?			
Stroke- When?			
Numbness anywhere			
RESPIRATORY			
Shortness of breath at rest			
Recent cold or sore throat			
Chronic cough			
Asthma- Episodes/wk			
Emphysema			
Use of Inhalers- Times/wk			
Home oxygen			
Snoring/Sleep apnea			
If yes, do you use CPAP?			
CARDIOVASCULAR			
High blood pressure			
Heart Attack			
Chest pain(angina)			
Pacemaker/defibrillator			
Irregular heart rhythm			
Murmur			
Prosthetic heart valve			
Phlebitis/blood clots			
Congestive heart failure			
Circulation problems			
Heart catherization			
GASTROINTESTINAL			
Colonoscopy in last 10 yrs			
Flexsig scope in last 4 yrs			
Fecal Occult in last year			
If yes to above, provide date & Physican name:			
Swallowing problems			
GERD or heartburn			
Peptic ulcer disease			
Hepatitis- A B C			
Nausea and vomiting			
GENERAL HEALTH			
Recent fever			
Recent chills			
Unexplained weight loss			
Loss of appetite			

ENDOCRINE	**YES**	**NO**	**Comments**
Diabetes- How long?			
Insulin- Oral Agent?			
Thyroid disease			
HEMATOLOGIC			
If an emergency are you willing to receive blood transfusion?			**YES or NO**
Anemia			
Bleeding problems			
SKIN/LYMPHATICS			
Rashes			
VRE/ History of MRSA			
CANCER			
What type?			
When?			
Treatment?			
MUSCULOSKELETAL			
Neck or back problems			
Arthritis			
Physical Limitations			
GENITOURINARY			
Kidney Failure			
Liver Failure			
Infections			
MEN:			
Prostate Problems or issues			
WOMEN:			
Date of Last menstrual period:			
Could you be pregnant?			
#pregnancies # live births			
Birth control: Yes No **TYPE:**			
Date of Last mammogram:			
OTHER INFORMATION			
Do you have a health directive?			emp. Initial/date
Copy Requested Declined Received			emp. Initial/date
Do you live alone?			
Do you have Prosthesis/Implants?			
Artificial Heart Valve			
Artificial Joint			
Artificial Eye			
Artificial limb			
Hearing Aids			
Dentures- Full- Upper___ Lower___			
Partial- Upper___ Lower___			
Contact lenses Glasses			
Walker/Wheelchair/Cane			
AIDS			
Do you have a history of alcoholism?			
Do you have a history of drug abuse?			

Continue on other side