



NorthStar Surgery

Specialists, P.A.

12319 N. Mopac Expy STE 350

Austin, TX 78758

Phone: 512-491-6542 | Fax: 512-491-0161

Medical History Form

Patient Name: _____
First Middle Last

Date of Birth: ____ / ____ / ____ Sex M F Height: _____ Weight: _____

Primary Care Physician: _____ Referring Physician: _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Chief Complaint / Purpose of Visit: _____

Medical History - Please list all Current and Past Medical Conditions: None

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> COPD/Emphysema/Bronchitis | Other: _____

_____ |
| <input type="checkbox"/> Previous Heart Attack / Chest Pain | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Other Lung Disease
Type: _____ | |
| <input type="checkbox"/> Heart Valve Disorders | <input type="checkbox"/> Cancer
Type: _____ | |
| <input type="checkbox"/> Heart Rhythm Problems | <input type="checkbox"/> Gall Bladder Disease
Type: _____ | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bowel Disease
Type: _____ | |
| <input type="checkbox"/> High Cholesterol / Lipids | <input type="checkbox"/> Hepatitis / Liver Disease
Type: _____ | |
| <input type="checkbox"/> History of Stroke | <input type="checkbox"/> Kidney / Bladder Disease
Type: _____ | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease
Type: _____ | |
| <input type="checkbox"/> Peripheral (Leg) Vascular Disease | | |
| <input type="checkbox"/> Epilepsy / History of Seizures | | |
| <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> Anemia | | |
| <input type="checkbox"/> Stomach Ulcer | | |
| <input type="checkbox"/> Clotting / Bleeding Disorder
Type: _____ | | |

Please list any pertinent descriptions, if needed, of any above conditions checked:

Surgical History - Please list Previous Operations and the year when they were performed: None

- | Procedure | Year | Procedure | Year | Procedure | Year |
|--|-------|---|-------|---|-------|
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | _____ | <input type="checkbox"/> Coronary Artery Bypass | _____ | <input type="checkbox"/> Thyroid | _____ |
| <input type="checkbox"/> Appendix (Appendectomy) | _____ | <input type="checkbox"/> Other Heart Surgery | _____ | <input type="checkbox"/> Breast Biopsy/Mastectomy | _____ |
| <input type="checkbox"/> Hernia Repair (any) | _____ | <input type="checkbox"/> Lung Surgery | _____ | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Stomach/Bowel Surgery | _____ | <input type="checkbox"/> Joint/Back Surgery | _____ | <input type="checkbox"/> Plastic Surgery | _____ |
| <input type="checkbox"/> Rectal/Hemorrhoid | _____ | <input type="checkbox"/> Hysterectomy/C-Section | _____ | <input type="checkbox"/> Skin surgery (Mole Removal, Graft, etc.) | _____ |
| <input type="checkbox"/> Other _____ | | | | | |

Medications - Please list all medications you are taking, including over-the-counter and herbal: None



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Allergies – Please list any allergies to medications below: None Latex

Social History:

Marital Status:

- Single
- Married
- Divorced
- Widowed

Do you have children?

- Yes
- No
- How many? _____
- Ages _____

Do you smoke or chew tobacco?

- Never Packs per day: _____
- Chew Number of years: _____
- Smoke Have you tried to quit? Yes No
- Former Smoker → Date Quit _____

Do you use illicit drugs? Yes No

Type and Frequency _____

Do you drink alcohol? Yes No

Type and Frequency _____

Occupation _____

Family History: Does anyone in your family have any of the following? If so, list your relation to them:

- | | |
|--|--|
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Epilepsy / Seizures _____ |
| <input type="checkbox"/> Ovarian/Uterine Cancer _____ | <input type="checkbox"/> GallBladder Disease _____ |
| <input type="checkbox"/> Melanoma _____ | <input type="checkbox"/> Bleeding / Clotting History _____ |
| <input type="checkbox"/> Prostate Cancer _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Lung Cancer _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Pancreatic Cancer _____ | <input type="checkbox"/> Lung Disease _____ |
| <input type="checkbox"/> Lymphoma / Leukemia _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Thyroid Cancer _____ | <input type="checkbox"/> High Lipids / Cholesterol _____ |
| <input type="checkbox"/> Skin Cancer _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other Cancer (Type and Family Member) _____ | <input type="checkbox"/> Other _____ |

Hospital preference, if needed: St. David's Seton

Will you absolutely refuse blood transfusions under any circumstances? Yes No

X-Rays / Labwork done: None
 Yes – Type and Location: _____

Who is accompanying you today? _____

If you are under 18 years old, what school grade are you in? _____

Are your immunizations up to date? Yes No



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Have you ever been treated by a physician for any of the following? Please check the box if "Yes."

Please explain any "Yes" answers at the bottom of this page and write the year you were diagnosed and/or treated.

General:

- Weight Loss _____lbs
- Weight Gain _____lbs
- Last Tetanus shot (year) _____

Eyes

- Glaucoma
- Cataracts
- Recent vision changes

Cardiovascular

- Chest pain
- Irregular Heartbeat
- Shortness of breath
- Feet / leg swelling
- Varicose veins

Women Only:

- Last menstrual period started _____
- Number of pregnancies _____
- Number of deliveries _____
- Last pap smear (date) _____
- Menstrual irregularities
- Menopause, age? _____
- Vaginal discharge
- Venereal disease

Men Only

- Prostate disease
- Testicular lumps, pain
- Venereal disease

Gastrointestinal

- Abdominal pain
- Heartburn
- Constipation
- Diarrhea
- Blood in stool
- Last Colonoscopy (year) _____
- Last Flex. Sig. (year) _____
- Last stool occult blood test (year) _____

Urinary

- Painful urination
- Slow/frequent urination
- Infections
- Blood in urine
- Kidney stones

Breast

- Last mammogram (date) _____
- Monthly self exams
- Lumps
- Nipple discharge
- Pains

Hematologic/Lymphatic

- Easy bleeding or bruising
- Anemia
- Blood transfusion (year) _____

Musculoskeletal

- Fractures/dislocations
- Muscle pain/cramps

Neurologic

- Headaches
- Weakness
- Dizziness
- Numbness / tingling

Psychiatric

- Depression
- Trouble sleeping
- Schizophrenia
- Alcohol dependency
- Drug dependency

Respiratory

- Cough
- Trouble breathing
- Wheezing
- Pneumonia

Ears/Nose/Mouth/Throat

- Hearing loss
- Nose bleeds
- Gum problems
- Sore throat
- Hoarseness
- Trouble swallowing

Immunologic

- HIV / AIDS
- Hepatitis (A, B, or C?)

Skin

- Rashes / dermatitis
- Changes in moles

Please explain any "Yes" answers below:
