Dr. Rene Alvarez
General Surgeon
907-235-1010/907262-5111
Peninsula Surgery & Aesthetics

PATIENT HEALTH HISTORY

Name: _____ Today's Date:_____

Primary care physician:_____ Birthdate: _____

Did anyone refer you to our office or how did you find us? _____

Why are you seeing us today?_____

Surgical History (please circle any surgeries you have had and indicate when):

Gallbladder	Plastic Surgery	Thyroid	Knee/hip replacement
Hernia	Hysterectomy	Heart Surgery	Back Surgery
Colon	Caesarean Section	EGD	Colonoscopy
Appendectomy	Prostate	Breast	Colostomy/Ileostomy

Other Operations (please list type): _____

Was there bleeding or anesthetic complications with any of your operations or procedures? Yes/No

If yes, please explain: _____

Past or present medical problems (circle any problems you have or had):

Diabetes	Anemia	Irregular heart rate	Irritable Bowel Syndrome
Fibromyalgia	HIV/AIDS	Stroke	Hemorrhoids
Seizures	Hepatitis (A,B,C)	High blood pressure	Ulcers
Tuberculosis	Jaundice	Heart condition	GERD
Pneumonia	Skin Condition	Heart attack	Goiter
Emphysema	Depression	High cholesterol	Head Injury
Asthma	Melanoma	Obstructive Sleep Apnea	

Cancer (where/ when?): _____

Other medical conditions: _____

Family history (are there any conditions that run in your family? Please list who and what type of illness.)
_____

_____

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Page Two - Patient Health Questionnaire

Medications:	**Dosage (mg/strength):**	**Number of times per day:**

Medical Allergies (please include reaction): _____

_____

Are you sensitive to latex? Yes/No Are you allergic to Iodine: Yes/No

Social history:

Marital Status: S M D Widow(er) Partner's Name_____ Contact number_____

How many children_____ Occupation_____ Employer_____

Do you smoke? Yes/No Packs per day_____ How many years?_____ Quit (how long ago?) _____

Do you drink alcohol Yes/No If yes, how much? Daily/Weekly/Monthly/Rarely Type_____

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Page Three - Patient Health Questionnaire

Review of Systems

Do you NOW HAVE or HAVE YOU HAD any problems related to the following body systems?

Please circle YES or No and explain any yes answers in the space provided.

General Symptoms		**Skin**	
Fever Yes No		Changing moles Yes No	
Chills Yes No		Rash Yes No	
Weight Loss Yes No		Boils Yes No	
		Itching Yes No	
Vision		**Musculoskeletal**	
Blurring Yes No		Joint pain Yes No	
Doubling Yes No		Neck pain Yes No	
Blindness Yes No		Back pain Yes No	
Allergy		**Ear/Nose/Throat**	
Hay Fever Yes No		Infection Yes No	
Drug Allergy Yes No		Sinus problems Yes No	
Other Yes No		Snoring Yes No	
Neurologic		**Urinary**	
Tremors Yes No		Incontinence Yes No	
Dizziness Yes No		Painful Yes No	
Numbness Yes No		Frequency Yes No	
Stroke Yes No		Difficulty Yes No	
TIA Yes No			
Gastrointestinal		**Respiratory**	
Difficulty swallowing Yes No		Wheezing Yes No	
Abdomen pain Yes No		Persistent cough Yes No	
Nausea Yes No		Short of breath Yes No	
Vomiting Yes No		Wind easily Yes No	
Heartburn Yes No			
Appetite loss Yes No			
Bloody stools Yes No			
Heart		**Blood**	
Chest pain Yes No		Easily bruise Yes No	
Heart attack Yes No		Bleeding Yes No	
Palpitations Yes No		Blood clots Yes No	
Passing out Yes No		Swollen glands Yes No	
Psychological		**Can you climb two flights of stairs without stopping?**	
Are you satisfied with life? Yes No		Yes No	
Are you depressed? Yes No			
Have you ever been suicidal? Yes No			
Physician use: (comments/notes)			

Physician Signature: _____ Date: _____