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HEALTH HISTORY FORM
(Confidential)

NAME _____ Today's date _____

Pts Date of Birth _____ Age: _____

Reason for today's visit

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING -

List **ALLERGIES** to medications or substances -

List any operations you have had -

ANY FAMILY HISTORY OF BREAST CANCER? _____ YES _____ NO

Do you -

Smoke? _____ How much? _____

Drink? _____ How much? _____

Use drugs? _____

SYMPTOMS – Check symptoms you currently have or have had in the past year.

GENERAL
MEN only

- Chills
- Breast lump
- Depression
- Erection difficulties
- Dizziness
- Lump in testicles
- Fainting

- Fever

- Forgetfulness

- Headache
- Loss of sleep

- Loss of weight

- Nervousness

- Numbness

- sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips

- Back Legs
- Feet Neck

- Hands Shoulders

GASTROINTESTINAL

- Appetite poor

- Bloating

- Bowel changes

- Constipation
- Penis discharge
- Diarrhea
- Sore on penis
- Excessive hunger
- Other
- Excessive thirst
- Gas

WOMEN ONLY

- Hemorrhoids
- Abnormal Pap smear
- Indigestion
- Bleeding between periods
- Nausea
- Rectal bleeding
- Breast lump
- Stomach pain
- Extreme menstrual
- Vomiting
- Hot flashes
- Vomiting Blood
- Nipple discharge

- Painful intercourse

CARDIOVASCULAR

- Other

- Chest pain
- Date of last
- High blood pressure
- menstrual period _____
- Irregular heart beat
- Date of

EYE, EAR, NOSE, THROAT

- Bleeding gums

- Blurred vision

- Crossed eyes

- Difficulty swallowing

- Double vision

- Earache

- Ear discharge
- Hay fever

- Hoarseness

- Loss of hearing

- Nosebleeds

- Persistent cough

- Ringing in ears

- Sinus problems

- Vision – flashes

- Vision – Halos

SKIN

- Bruise easily

- Hives

GENITO-URINARY

- | | | |
|-----------------------------|--------------------------|--------------------------|
| Poor circulation _____ | ___ Low blood pressure | ___ Itching |
| Blood in urine _____ | Pap smear _____ | Have you had a |
| Frequent urination _____ | ___ Change in moles | ___ Rash |
| ___ Lack of bladder control | ___ Rapid heart beat | ___ Scars |
| ___ Painful urination | mammogram? _____ | ___ Sore that won't heal |
| | ___ Swelling of ankles | |
| | Are you pregnant? _____ | |
| | ___ Varicose veins | |
| | Number of children _____ | |
-

CONDITIONS: Check conditions you have or have had in the past.

- | | | |
|------------------------|-------------------------|------------------------|
| ___ AIDS | ___ Chemical Dependency | ___ High cholesterol |
| ___ Alcoholism | ___ Prostate problem | ___ HIV positive |
| ___ Anemia | ___ Chicken pox | ___ Kidney disease |
| ___ Anorexia | ___ Psychiatric care | ___ Liver disease |
| ___ Appendicitis | ___ Diabetes | ___ Measles |
| ___ Arthritis | ___ Rheumatic fever | ___ Migraine headaches |
| ___ Asthma | ___ Emphysema | ___ Miscarriage |
| ___ bleeding disorders | ___ Scarlet fever | ___ Mononucleosis |
| ___ Breast lump | ___ Epilepsy | ___ Multiple sclerosis |
| ___ Bronchitis | ___ Stroke | ___ Mumps |
| ___ Bulimia | ___ Glaucoma | ___ Pacemaker |
| ___ Cancer | ___ Suicide attempt | ___ Pneumonia |
| ___ Cataracts | ___ Goiter | ___ Polio |
| | ___ Thyroid problems | |
| | ___ Gonorrhea | |
| | ___ Tonsillitis | |
| | ___ Gout | |
| | ___ Tuberculosis | |
| | ___ Heart disease | |
| | ___ Typhoid fever | |
| | ___ Hepatitis | |
| | ___ Ulcers | |
| | ___ Hernia | |
| | ___ Vaginal infections | |
| | ___ Herpes | |
| | ___ Venereal disease | |

FAMILY HISTORY: Fill in health information about your family.

Relationship	Age Age & cause of death	State of health
Father	_____	_____
Mother	_____ _____	_____
Sisters/brothers	_____ _____ _____ _____ _____	_____ _____ _____

Have you ever had a blood transfusion? _____ YES _____ NO Approximate date

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient signature Date

Reviewed by Date
