**Roger J. Oldham / Bethesda Surgery Center, LLC**

**HEALTH HISTORY**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_SEX\_\_\_\_\_\_HGT.\_\_\_\_\_\_WGT.\_\_\_\_\_\_

**PLEASE CIRCLE IF YOU HAVE A HISTORY OF:**

GENERAL WEIGHT LOSS, SEXUALLY/BLOOD TRANSMITTED DISEASE.

EYES BLURRED VISION, DOUBLE VISION, GLAUCOMA.

ENT - PERSISTENT SORE THROAT, BLEEDING GUMS.

RESPIRATORY PERSISTENT COUGH, ASTHMA, LUNG PROBLEMS.

CARDIOVASCULAR CHEST PAIN, IRREGULAR HEART BEAT, HEART ATTACK, HEART PROBLEMS.

GASTROINTESTINAL BLOOD IN STOOL, CHANGE IN BOWEL HABITS, LIVER DISEASE.

GENITOURINARY BURNING ON URINATION, BLOOD IN THE URINE, KIDNEY OR BLADDER PROBLEMS.

MUSCULOSKELETAL BACK PAIN, JOINT PAIN.

ENDOCRINE DIABETES, THYROID DISEASE.

LYMPH/HEMO PROLONGED BLEEDING, SWOLLEN GLANDS

NEUROLOGICAL DIZZINESS, FAINTING EPISODES, SEIZURES.

PSYCHIATRIC NERVOUS BREAKDOWN OR MENTAL ILLNESS.

PAST SURGERY:

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PAST OR PRESENT MEDICAL CONDITIONS OR ILLNESSES:

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ARE THERE ANY MEDICAL CONDITIONS WHICH SEEM TO RUN IN YOUR FAMILY? IF YES, PLEASE EXPLAIN.

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HAVE YOU EVER HAD SKIN CANCER? \_\_\_YES \_\_\_\_NO IF YES, WHAT TYPE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SMOKE? YES\_\_\_\_ NO\_\_\_\_ HOW MUCH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW MANY YEARS\_\_\_\_\_

DO YOU DRINK ALCOHOL? YES\_\_\_\_ NO\_\_\_\_ HOW MUCH\_\_\_\_\_\_\_\_\_\_\_\_DAILY \_\_\_\_\_\_ WEEKLY \_\_\_\_\_\_\_

If you are a male, 65 years old or younger, do you drink more than 14 standard drinks per week or more than 4 drinks per occasion? YES \_\_\_\_\_ NO \_\_\_\_\_ NOT APPLICABLE \_\_\_\_\_

If you are a female of any age or a male over 65 years of age, do you drink more than 7 standard drinks per week or more than 3 drinks per occasion? YES \_\_\_\_\_ NO \_\_\_\_\_\_ NOT APPLICABLE \_\_\_\_\_

FOR WOMEN - LAST MENSTRUAL PERIOD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT COUNSELED: A T N/A Physician’s Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_