Richmond Surgical
HCA Virginia Health System
An HCA affiliate

Patient History

Patient Name: _____

Age: _____ Date _____ Date of Birth _____

Height _____ Weight _____

Describe your problem or injury: _____

_____

Date of onset of the problem: _____

Name of Primary Care Physician: _____

Other Physicians you are currently seeing: _____

Past Medical History

Previous Operations: (Please list surgery, approximate date of surgery, name of surgeon and hospital where performed):

_____

_____

Previous Major Illnesses & Non-Surgical Hospitalizations: _____

_____

(Please check if you are currently receiving treatment or have received treatment in the past for any of the following conditions)

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Birth Defects
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Currently Pregnant
- ❑ Diabetes
- ❑ Heart Disease(s)
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Intestinal Disorders
- ❑ Kidney Disease
- ❑ Phlebitis (blood clots)
- ❑ Recurrent Infections
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Ulcers
- ❑ Other (Please Specify) _____

Medications

Are you taking any prescription or over the counter medications? ❑ Yes ❑ No

If yes, please list medications, dosage, how long you have been taking and the name of the prescribing physician:

_____

_____

_____

_____

Drug Allergies: (Please list any drugs/substances to which you have had a reaction, and describe the reaction):

_____

_____

Review of Systems

(Please describe which of the following symptoms you have experienced regularly in the past)

General:	❑ Fever	❑ Night sweats	❑ Weight loss	❑ Daytime sleepiness
Eyes:	❑ Blurring	❑ Eyestrain	❑ Glasses/contacts	❑ Discharge
Throat:	❑ Soreness	❑ Hoarseness	❑ Difficulty swallowing	
Gastrointestinal:	❑ Nausea	❑ Vomiting	❑ Belching/Indigestion	❑ Constipation ❑ Diarrhea ❑ Heartburn/reflux
Skin:	❑ Eruptions/rashes	❑ Cyanosis	❑ Jaundice (yellow tint)	
Ears:	❑ Deafness	❑ Ringing in ears	❑ Pain	❑ Discharge
Genitourinary:	❑ Pain	❑ Frequent urination	❑ Incontinence	❑ Urination at night
Musculoskeletal:	❑ Weakness	❑ Joint pain	❑ Tingling	❑ Low back pain ❑ Deformities
Head:	❑ Headache	❑ Dizziness/blackouts	❑ Trauma	
Nose:	❑ Sinusitis	❑ Obstruction		
Respiratory:	❑ Asthma	❑ Difficulty breathing	❑ Bloody sputum	❑ Date last chest x-ray: _____
Cardiovascular:	❑ Chest pain	❑ Faintness	❑ Varicose veins	❑ Rapid or throbbing heartbeat
	❑ Fluid/swelling around extremities		❑ Pain in legs when walking	

Female Reproductive

Number of pregnancies: _____ Number of deliveries: _____

Date of last routine exam: _____ Date last menstrual period: _____

Date of last mammogram: _____ Periods regular? _____

Family History

(Have mother, father, grandparents, brothers, sisters been treated in the past or currently receiving treatment for any of the following conditions?)

❑ Arthritis ❑ Cancer ❑ Diabetes ❑ Heart Disease

❑ High Blood Pressure ❑ Kidney Disease ❑ Other (Please Specify) _____

Please list health status or cause of death for the following family members:

Mother: _____

Father: _____

Siblings: _____

Children: _____

Social History

Martial Status: ❑ Single ❑ Married ❑ Other

Occupation: _____ ❑ Full Time ❑ Part Time ❑ Student

Next of Kin: _____ Telephone: _____

Do you now or have you previously used tobacco products? ❑ Yes ❑ No

If yes, products and amount per day_____ Duration _____

Do you consume alcohol products? ❑ Yes ❑ No If yes, amount & frequency: _____

Patient Signature: _____ Date: _____