Valley Surgical Specialists Medical Group
BSV Medical Pavilion
782 Medical Center Drive East #101
Clovis, CA 93611
(559) 256-4111

Valley Surgical Specialist Medical Group **Medical HX Form**

A Member Of Community Foundation Medical Group & Sante Health Foundation

NAME: _____ DOB: _____ DATE: _____ MR#: _____

Referring MD: _____ Primary Care Physician: _____

Reason you are seeing the doctor today? _____

MEDICAL HISTORY: (please check)

- ☐ Cardiac disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Diabetes
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Other: _____
- ☐ Other: _____

CURRENT MEDICATIONS AND DOSAGES: (including aspirin, blood thinners, and any herbal medications) or provide list

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

MEDICATION ALLERGIES: (Penicillin, Sulfa, Morphine, Demerol, etc.) Latex Allergy: Yes ☐ No ☐

_____

PAST SURGERIES: (include approximate year if known)

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

FAMILY HISTORY:

Number of Brothers: ____ Number of Sisters: ____

Cardiac Disease: Yes ☐ No ☐ Diabetes: Yes ☐ No ☐ High Blood Pressure: Yes ☐ No ☐

Whom: _____ Whom: _____ Whom: _____

Cancer of: Breast ☐ Ovarian ☐ Colon ☐ Prostate ☐ N/A ☐ Other type of cancer: _____

Relation & Age: _____

SOCIAL HISTORY:

Do you smoke? Yes ☒ No ☐ How many years? ____ Number of packs per day? ____ When did you quit? _____

Do you drink alcohol? Yes ☒ No ☐ Frequently ☐ Seldom ☐ Socially ☐

Profession: _____ Retired ☒ Student ☐

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NAME: _____

REVIEW OF SYSTEMS: **Circle YES or NO**

General
Fever / chills ☒Yes ☐No
Night wweats ☒Yes ☐No
Fatigue ☒Yes ☐No
Weight changes ☒Yes ☐No

Skin
Cancer ☒Yes ☐No
Rash ☒Yes ☐No
Change in mole ☒Yes ☐No
Persistent itching ☒Yes ☐No
Bruise easily ☒Yes ☐No

HEENT
Glasses ☒Yes ☐No
Dizziness ☒Yes ☐No
Vertigo ☒Yes ☐No
Hearing Loss ☒Yes ☐No
Headaches ☒Yes ☐No

Cardiac
Chest pain / Angina ☒Yes ☐No
Palpitations ☒Yes ☐No
High blood pressure ☒Yes ☐No
Edema ☒Yes ☐No
Name of Cardiologist: _____

Respiratory
Frequent cough ☒Yes ☐No
Asthma ☒Yes ☐No
Shortness of breath ☒Yes ☐No
Tuberculosis ☒Yes ☐No

Gastrointestinal
Heartburn ☒Yes ☐No
Nausea / vomiting ☒Yes ☐No
Diarrhea ☒Yes ☐No
Constipation ☒Yes ☐No
Change in stool ☒Yes ☐No
Diverticulitis ☒Yes ☐No
Irritable bowel disease ☒Yes ☐No
Last Colonoscopy: _____

Urinary
Urine retention ☒Yes ☐No
Incontinence ☒Yes ☐No
Frequency ☒Yes ☐No
Blood in urine ☒Yes ☐No

Hematologic
Prior blood transfusion ☒Yes ☐No
Blood clotting problem ☒Yes ☐No
Excessive bleeding w/ injuries ☒Yes ☐No

Neurological
Seizures ☒Yes ☐No
Stroke ☒Yes ☐No
Tremor ☒Yes ☐No
Fainting ☒Yes ☐No

Psychological
Depression ☒Yes ☐No
Anxiety ☒Yes ☐No
Insomnia ☒Yes ☐No

Musculoskeletal
Arthritis ☒Yes ☐No
Back pain ☒Yes ☐No
Fibromyalgia ☒Yes ☐No

Endocrine
Too hot / too cold ☒Yes ☐No
Excessive weight gain / loss ☒Yes ☐No
Dry skin ☒Yes ☐No
Diabetes ☒Yes ☐No

Allergy
See 1st page

Cancer
Type: _____
Oncologist: _____
Chemotherapy _____
Radiation Therapy _____

FOR BREAST PATIENTS / WOMEN ONLY:

Number of pregnancies _____ Live births _____ Age at 1st pregnancy _____
Age at 1st period _____ Date of last period _____ Date of last mammogram _____ Date of last PAP _____
Did you breast feed _____ How long _____ Bra cup size _____
Have you used hormone replacement or birth control pills / injections (circle) For how long? _____
Do you practice routine breast self-examination Yes☐ No☐
Family History of Breast Cancer: Relation/Age _____ Relation/Age _____
Family History of Ovarian Cancer: Relation/Age _____ Relation/Age _____

MD Signature: _____ Date: _____