



Please complete this medical history form and mail it to the address below or fax the form to 269-979-6406.

*Family Surgical, P.C.
3600 Capital Avenue, S.W,
Suite 103
Battle Creek, MI 49015*

If time does not allow for the form to be mailed prior to your scheduled appointment and you do not have access to a fax, please bring completed form to appointment with you.

Thank you for your assistance and we look forward to your visit to our office.

The Physicians and Staff of Family Surgical, P.C.



Medical History Form

Date _____

Name: _____ Date of Birth: _____ Age: _____

Family Doctor: _____ Referring Doctor: _____

Email Address of Referring Doctor (if known): _____

Chief Surgical Complaint

Childhood Illnesses (check all that apply)

- | | |
|-----------------|-------------|
| Measles | Asthma |
| Mumps | Seizures |
| Chickenpox | Polio |
| Rheumatic Fever | Other _____ |

Adult Illnesses (check all that apply)

- | | |
|---------------|----------------|
| Asthma | Kidney Stones |
| Diabetes | Glaucoma |
| Heart Disease | Kidney Disease |
| Hypertension | Depression |
| Stroke | Gerd |
| Emphysema | Sleep Apnea |
| Ulcers | Osteoarthritis |
| Hepatitis | Other _____ |

Previous Surgeries (check all that apply)

- | | |
|-----------------|---------------|
| Tonsillectomy | Breast Biopsy |
| Hysterectomy | Hernia |
| C-Section | Gall Bladder |
| Appendectomy | Heart |
| Ovaries Removed | Other _____ |

Medications you are currently taking (please list all)

Medication Allergies (please list all)

Family Medical History

Early Heart Disease
Cancer (please specify type of cancer) _____
Diabetes
Hypertension
Stroke
Other _____

List family member(s) and disease(s) noted above:

Social History (select one)

Single Divorced
Married Widowed

Occupation _____

Do you currently or have you ever smoked? No Yes
How many years? _____
When did you quit? _____

Do you drink alcohol? No Yes
How many drinks do you consume per week? _____

Do you take drugs? No Yes
If yes, please list: _____

Glands:

Thyroid Disease
Abnormal Lymph Nodes

Heart:

Chest Pain Heart Murmur
Rapid/Irregular Heartbeat Heart Failure

Lungs:

Shortness of Breath Coughing Blood
Cough Wheezing

Abdomen:

Liver Disease Hepatitis
Heartburn Vomiting blood
Food Intolerance Blood in stools
Diarrhea Black-tarry stools
Ulcers Constipation
Pains

Urinary:

Leaking Painful voiding
Blood in Urine Infections
Kidney Stones Prostrate problems

Bone/Joint:

Arthritis Joint swelling
Artificial Joints Leg Pains
Gout

Women's Issues

Number of Pregnancies _____ Number of Live Births _____ Abortions/Miscarriages _____

Date of last menses _____ Abnormal Bleeding No Yes

Date of last Pap _____ Do you still have your ovaries? No Yes

Do you take or use any of the following?

Hormones
Birth Control

Age started having periods _____ Menopause Age _____

Age of first pregnancy _____ Age of last pregnancy _____

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