ERIC R. DRINGMAN, M.D., F.A.C.S.
KATHRYN F. HATCH, M.D., F.A.C.S.
BARRY A. McKENZIE, M.D., F.A.C.S.
RACHEL L. OTT, M.D., F.A.C.S.

SURGICAL ASSOCIATES PC
2900 12th Ave North, Suite 355W, Billings, MT 59101
(P) 406-238-6470 / (F) 406-238-6499
www.billingssurgeons.org

GEORGE K. BENTZEL, M.D., F.A.C.S.
JEFFREY J. RENTZ, M.D., F.A.C.S.
MICHAEL G. WILCOX, M.D., F.A.C.S.

HEALTH HISTORY INTAKE SHEET

Patient Name: _____ Patient DOB: _____

What is the main health concern/reason for today's visit? _____

SURGICAL HISTORY: List all surgical procedures, location on the body and the year performed (i.e. joint replacement, tonsillectomy, wisdom teeth, Lasik, hysterectomy, etc.)

☐ Check this box if you NEVER had a surgical procedure.

TYPE of SURGERY	AREA on BODY	YEAR

Do have any history with anesthesia problems with surgery?

☐ No
☐ Yes, please explain_____

Name of Primary Care Physician:_____

MEDICAL HISTORY: Have you been and/or are you currently being treated for any of the following?

Unexplained Weight Loss	Y___ N___	Skin Cancer	Y___ N___
Recent Fever	Y___ N___	Breast Problems	Y___ N___
Hearing Loss	Y___ N___	Stroke	Y___ N___
Hoarseness	Y___ N___	Seizure	Y___ N___
Heart Disease	Y___ N___	Sleep Apnea	Y___ N___
Rhythm problems	Y___ N___	Brain Injury	Y___ N___
Congestive Heart Failure	Y___ N___	Depression	Y___ N___
Asthma	Y___ N___	Anxiety	Y___ N___
Chronic Cough	Y___ N___	Seasonal Allergies	Y___ N___
COPD	Y___ N___	Auto Immune Disorder	Y___ N___
Shortness of Breath w/Exertion	Y___ N___	Arthritis	Y___ N___
Smoker	Y___ N___	Hepatitis	Y___ N___
High Blood Pressure	Y___ N___	Blood in Stools	Y___ N___
Thyroid Disease	Y___ N___	Reflux	Y___ N___
Diabetes	Y___ N___	Bladder Problems	Y___ N___
Deep Vein Thrombosis	Y___ N___	Kidney Problems	Y___ N___
Blood Clotting Problems	Y___ N___	Other_____	
Bleeding Problems	Y___ N___	_____	

Do you use/have any of the following devices (please circle all that apply):

CPAP Machine Pacemaker Stimulator (type_____)

OFFICE USE ONLY: WT_____ HT_____ BMI_____ BP_____ P_____ O2_____

HOSPITALIZATIONS: List any time you spent one or more nights in a hospital, the reason whyand the year it occurred.

☐ Check this box if you have NEVER been hospitalized.

REASON	YEAR

ALLERGIES: List any medications that you are allergic to and/or cause a reaction.

☐ Check this box if you have NO known allergies/reactions to medication.

MEDICATION	REACTION

CURRENT MEDICATION LIST: List all prescription and over-the-counter medicines you take on a regular basis, why you are taking them and who the physician is that prescribed them for you.

☐ Check this box if you are currently NOT taking any medications.

NAME	STRENGTH	FREQUENCY	WHY	WHO PRESCRIBED

Are you being treated for chronic pain?

☐ No

☐ Yes

If Yes, do you have a pain contract and with who?_____

What pharmacy do you prefer to use?

_____

(Name) *(Address)* *(Phone#)*

If you are 65 or older, please answer the following:

- Have you had any falls in the past year? (circle one) YES NO
- If yes, how many?_____
- If yes, were you injured?_____

FAMILY HEALTH HISTORY: Please answer the following questions based on immediate blood relatives.

☐ Check this box if you were adopted and are unsure of your family health history.

Father

☐ Alive current age_____ chronic health conditions_____

☐ Deceased age at death_____ cause of death_____

Mother

☐ Alive current age_____ chronic health conditions_____

☐ Deceased age at death_____ cause of death_____

Siblings

☐ Brothers, how many_____ chronic health conditions_____

☐ Sisters, how many_____ chronic health conditions_____

Children

☐ Sons, how many_____ chronic health conditions_____

☐ Daughters, how many_____ chronic health conditions_____

Is there a family history of cancer? (circle one) YES NO If yes, please list who and what type of cancer.

FAMILY MEMBER	TYPE OF CANCER

Is there a family history of bleeding problems? (circle one) YES NO

Are there any other prominent family health conditions you want us to be aware of?(circle one) YES NO
If yes, please explain_____

SOCIAL HEALTH HISTORY:

Do you currently use any tobacco or nicotine products, including cigarettes, chew, e-cigs and/or vape?

☐ Yes

If Yes, which kind?_____ How much/day?_____

☐ No

If no, have you previously?(circle one) YES NO If yes, when did you quit? _____

Do you currently use marijuana, recreational and/or intravenous drugs?

☐ No

☐ Yes

If Yes, which kind?_____ How often?_____

Do you currently drink alcohol, including beer, wine, and/or hard liquor?

☐ No

☐ Yes

If Yes, which kind?_____ How often?_____

Marital Status(circle one):Married Partner Single Divorced Widow Spouse/Partner Name:_____

Employment Status(circle one):Employed Retired Student None Place of Employment:_____

Patient/Guardian Signature: _____Date: _____

If this form is not signed by the patient complete the following:

Printed Name: _____Relationship to Patient: _____