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.
JUSTIN C. BREWER, M.D.

HEALTH HISTORY INTAKE SHEETS (3 Pages)

Patient Name_____
(First) (M.I.) (Last)

Mailing Address_____
(Street) (City) (State) (Zip)

Home Phone( )_____Cell Phone( )_____Email_____

Birthdate_____ Sex(circle one) M F Marital Status(circle one) M S D W P SSN_____

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

Primary Care Provider_____ Referring Provider_____

What local pharmacy do you prefer to use?

_____
(Name) *(Address)* *(Phone/Fax#)*

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. You can also attach a list if you need more space.

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

NAME	STRENGTH	FREQUENCY	WHY	WHO PRESCRIBED

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 medications.

MEDICATION	REACTION

OFFICE USE ONLY: WT_____ HT_____ BMI_____ BP_____ P_____ O2_____

SURGICAL HISTORY: List all surgical procedures, location on the body and the year performed (i.e. joint replacement-knee, 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 during surgery?

☐ No

☐ Yes, please explain_____

HOSPITALIZATIONS: List any time you spent one or more nights in a hospital (other than surgeries listed above), the reason why and the year it occurred.

☐ Check this box if you have NEVER been hospitalized.

REASON	YEAR

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_____

Do you or an extended family member have a 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?

☐ Yes

If Yes, which kind? _____ How often? _____

☐ No

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

☐ Yes

If Yes, which kind? _____ How often? _____

☐ No

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

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

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

CPAP Machine Pacemaker Stimulator (type_____)

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? _____

Patient/Guardian SIGNATURE: _____Date: _____

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

Printed Name: _____Relationship to Patient: _____