ZEMAN SURGICAL CLINIC

Confidential Health Questionnaire

PLEASE ADVISE US IF YOUR ADDRESS, EMPLOYER, INSURANCE OR FAMILY PHYSICIAN HAS CHANGED SINCE YOUR LAST VISIT.

Patient Name_____ Date_____
Date of birth_____ Age_____ Family Physician_____

Current Medications: _____

Allergies to medications or latex: _____

Please list ***ALL*** past surgeries ***including colonoscopy/ EGD*** or other endoscopy: _____

CIRCLE ALL SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE PAST 12 MONTHS- CIRCLE ALL THAT APPLY

Weakness
Heartburn
Loss of appetite
Nausea
Vomiting
Vomiting blood
Indigestion
Trouble swallowing

Constipation
Diarrhea
Abdominal Pain
Changes in bowel habits
Rectal bleeding
Pain with bowel movement
Excessive gas or bloating
Weight loss or gain

Asthma
High blood pressure
Rheumatic fever
Hepatitis
Heart trouble
Shortness of breath
Chest pain or discomfort
Dizziness or headache

Please indicate which substances you use, now or in the past, and the quantity in which you use or have used them:

Caffeine_____ Tobacco_____

Drugs_____ Other_____

Have you ever been diagnosed with cancer? _____ If so, what type? _____

Do you have a family history of cancer? _____ If so, what type? _____

Are you diabetic? _____ Do you have a family history of diabetes? _____

Have you ever seen Dr. Charles Zeman, Dr. Rex Hardman or Dr. Robert Madsen.....at any time, either here or at the hospital?_____

Family Physician _____ Referred/ Scheduled by_____
(A referring doctor will receive a copy of your office notes/tests ordered/procedures performed ...this also applies if Dr. Zeman sends you elsewhere for referral and/or consultation)

If your family physician did not refer or schedule this appointment, would you like for her/ him to receive a copy of your office records? _____ Any other physicians to receive copies?_____

FOR WOMEN ONLY

Last menstrual period_____ Menstrual frequency_____
Severity of flow_____ Any clotting_____
Last pap smear_____ Have you ever had an abnormal pap_____
Last mammogram_____ Have you ever had an abnormal mammo_____
Number of pregnancies_____ Number of live births_____
Age of first pregnancy_____ Did you breast feed_____

HEIGHT_____ WEIGHT _____ TEMP_____ B/P_____ PULSE_____