Dr. Rene Alvarez
General Surgeon
907-235-1010/907262-5111
Alaskavida.com or drrenealvarez.com

PATIENT HEALTH HISTORY

Name: ____ Today's Date:__________________

Primary care physician:____ Birthdate: _____________________

Did anyone refer you to our office or how did you find us? ____

Why are you seeing us today?____

Surgical History (please circle any surgeries you have had and indicate when):

Gallbladder	Plastic Surgery	Thyroid	Knee/hip replacement
Hernia	Hysterectomy	Heart Surgery	Back Surgery
Colon	Caesarean Section	EGD	Colonoscopy
Appendectomy	Prostate	Breast	Colostomy/Ileostomy

Other Operations (please list type): ____

Was there bleeding or anesthetic complications with any of your operations or procedures? Yes/No

If yes, please explain: ____

Past or present medical problems (circle any problems you have or had):

Diabetes	Anemia	Irregular heart rate	Irritable Bowel Syndrome
Fibromyalgia	HIV/AIDS	Stroke	Hemorrhoids
Seizures	Hepatitis (A,B,C)	High blood pressure	Ulcers
Tuberculosis	Jaundice	Heart condition	GERD
Pneumonia	Skin Condition	Heart attack	Goiter
Emphysema	Depression	High cholesterol	Head Injury
Asthma	Melanoma	Obstructive Sleep Apnea	

Cancer (where/ when?): ____

Other medical conditions: ____

Family history (are there any conditions that run in your family? Please list who and what type of illness.)

____

____

Dr. Rene Alvarez

Page Two - Patient Health Questionnaire

Medications:	**Dosage (mg/strength):**	**Number of times per day:**

Medical Allergies (please include reaction): ____

____

Are you sensitive to latex? Yes/No Are you allergic to Iodine: Yes/No

Social history:

Marital Status: S M D Widow(er) Partner's Name_____________________________ Contact number___________

How many children__________ Occupation_________________________ Employer__________________________

Do you smoke? Yes/No Packs per day_____ How many years?______ Quit (how long ago?) ______

Do you drink alcohol Yes/No If yes, how much? Daily/Weekly/Monthly/Rarely Type_____________________

Dr. Rene Alvarez

Page Three - Patient Health Questionnaire

Review of Systems

Do you NOW HAVE or HAVE YOU HAD any problems related to the following body systems?

Please circle YES or No and explain any yes answers in the space provided.

General Symptoms Fever Yes No Chills Yes No Weight Loss Yes No		**Skin** Changing moles Yes No Rash Yes No Boils Yes No Itching Yes No	
Vision Blurring Yes No Doubling Yes No Blindness Yes No		**Musculoskeletal** Joint pain Yes No Neck pain Yes No Back pain Yes No	
Allergy Hay Fever Yes No Drug Allergy Yes No Other Yes No		**Ear/Nose/Throat** Infection Yes No Sinus problems Yes No Snoring Yes No	
Neurologic Tremors Yes No Dizziness Yes No Numbness Yes No Stroke Yes No TIA Yes No		**Urinary** Incontinence Yes No Painful Yes No Frequency Yes No Difficulty Yes No	
Gastrointestinal Difficulty swallowing Yes No Abdomen pain Yes No Nausea Yes No Vomiting Yes No Heartburn Yes No Appetite loss Yes No Bloody stools Yes No		**Respiratory** Wheezing Yes No Persistent cough Yes No Short of breath Yes No Wind easily Yes No	
Heart Chest pain Yes No Heart attack Yes No Palpitations Yes No Passing out Yes No		**Blood** Easily bruise Yes No Bleeding Yes No Blood clots Yes No Swollen glands Yes No	
Psychological Are you satisfied with life? Yes No Are you depressed? Yes No Have you ever been suicidal? Yes No		**Can you climb two flights of stairs without stopping?** Yes No	
Physician use: (comments/notes)			

Physician Signature: ____ Date: ____________________________