LAKESIDE SURGICAL
ASSOCIATES, PA

Health History
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Family History: Medical Conditions that are in your **Family**

Please list the family members with these problems: Father, Mother, Grandparent, Aunt, Uncle, Sister, Brother

☐	Eye Problems:	☐	Diabetes/ Sugar Problems:
☐	Stroke:	☐	Thyroid Disease:
☐	Epilepsy:	☐	Arthritis:
☐	High Blood Pressure:	☐	Colon Polyps:
☐	Heart Attack:	☐	Cancers (Type):
☐	Irregular Heart Beat:	☐	Melanoma:
☐	Congestive Heart Failure:	☐	Skin Cancer:
☐	Hepatitis (Type):	☐	Phlebitis/ Blood Clots:
☐	Stomach Ulcers:	☐	Anesthesia Problems:
☐	Reflux:	☐	Bleeding Disorder/ Hemophilia:
☐	Kidney Problems/ Stones/ Dialysis:	☐	Sickle Cell Anemia:
☐	Asthma/ Emphysema/ COPD:	☐	HIV/ AIDS:
☐	Gallbladder:	☐	Other:
☐	Pancreatitis:	☐	Other:

Review of Systems: **Personal Medical History:** ABOUT **YOU,** THE **PATIENT**

☐	Skin Changes:	☐	Constipation:
☐	Eye Problems:	☐	Diarrhea:
☐	Hearing Difficulty/Problems:	☐	Non-Healing Sores:
☐	Stroke:	☐	Unexplained Fevers:
☐	Chest Pain:	☐	Night Sweats:
☐	Shortness of Breath:	☐	Lethargy/Tiredness:
☐	Breast Changes:	☐	Severe Itching:
☐	Trouble Swallowing:	☐	Weight Loss- Unplanned:
☐	Food Getting Stuck:	☐	Leg Swelling:
☐	Heartburn:	☐	Pain in Legs:
☐	Reflux:	☐	Difficulty Urinating:
☐	Indigestion:	☐	Blood in Urine:
☐	Nausea:	☐	Kidney Problems:
☐	Vomiting:	☐	Depression:
☐	Abdominal Pain:	☐	Anxiety:
☐	Black Stool:	☐	Hair Loss:
☐	Blood in Stool:	☐	Other: