Winfield Surgery & Services

CHRISTOPHER A. MORRISSEY, DO
GENERAL SURGERY

Patient Name: _____ Date of Birth: _____

In order to provide the best care we need to know your history. Please take a few minutes to answer all questions. Please add any information you feel will help explain your health. If you need any help with this form, please ask. Thank you

PATIENT DEMOGRAPHICS AND CHIEF COMPLAINT

Today's Date: _____ Age: _____ Height: _____ Weight: _____

Why are you seeing the Doctor today? _____

When did you first have this problem? _____

General Health

	Recurrent Infections		Recurrent Fever		Fatigue
	Night Sweats		Recent weight gain		Recent weight loss
	Decreased appetite		No problems		

Skin

	Sores		Hair loss		Non-Healing Wound
	Changes in moles		New lesions		No Problems
	Rash		Lumps/Growths		

Head, Ears, Eyes, Nose, Throat

	Sore throat		Nose bleeding		Blurred vision
	Headaches		No Problems		

Lungs

	Difficulty Breathing		Cough		Sleep with more than 1 pillow
	Cough blood or mucus		Wheezing		No Problems

Breast

	Breast lumps/mass		Nipple discharge		No Problems
	Breast pain		Nipple pain		
	Breast swelling		Skin changes		

Winfield Surgery & Services

CHRISTOPHER A. MORRISSEY, DO
GENERAL SURGERY

Patient Name: _____ Date of Birth: _____

Heart

	Chest pain		Tightness		Thumping or pounding
	Heart murmur		Swollen arms or legs		Shortness of Breath
	Rheumatic Fever		High Blood Pressure		No Problems

Stomach and Intestinal

	Special Diet		Heartburn		Rectal bleeding
	Nausea		Indigestion		Blood in stool
	Vomiting		Black stools		Positive hemoccult
	Ulcers		Constipation		Diverticulosis
	Difficulty swallowing		Diarrhea		Diverticulitis
	No Problems				

Male Reproductive:

	Painful urination		Frequency		Impotence
	Prostate problems		Urgency		Testicular pain
	No problems				

Female Reproductive

	Painful urination		Frequency		Blood clots
			Urgency		No problems

Muscle, Bone, Joint

	Joint pain		Neck pain		Muscle cramping
	Muscle pain		Joint stiffness		Back pain
	Joint swelling				No problems

Nervous System

	Seizures		Decreased memory		Problems speaking
	Dizziness		Fainting		Problems moving
	Loss of consciousness		No Problems		

Veins (blood vessels), Lymphatic

	Abnormal bleeding		Easy bruising		Anemia
	Enlarged lymph nodes		No problems		

Winfield Surgery & Services

CHRISTOPHER A. MORRISSEY, DO
GENERAL SURGERY

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY

Please check the boxes below to indicate if your family members have had the following problems.
Under siblings please write brother or sister. Under grandmother please write maternal (mother) or paternal (father). Under grandfather please write maternal (mother) or paternal (father).

	Mother	Father	Siblings	Grandmother	Grandfather	Children	Aunt	Uncle
Problems with anesthesia								
Cancer – Breast								
Cancer – Colon								
Cancer – Ovarian								
Cancer – Pancreatic								
Cancer – Prostate								
Cancer – other								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								

SOCIAL HISTORY

What is your marital status? Married ☐ Single ☐ Divorced ☐ Widowed ☐

Do you smoke? ☐ **Yes** ☐ **No** If yes, how much per day and how many years? _____

Have you ever smoked? ☐ **Yes** ☐ **No** If yes, at what age did you quit? _____

Do you drink alcoholic drinks? ☐ **Yes** ☐ **No** If yes, how much and how often? _____

Do you take any drugs for reasons that are not medical? ☐ **Yes** ☐ **No**
If yes, please list:

Do you use a CPAP machine? ☐ **Yes** ☐ **No**

Winfield Surgery & Services

CHRISTOPHER A. MORRISSEY, DO
GENERAL SURGERY

Patient Name: _____ Date of Birth: _____

List all drug allergies and reactions:

Are you allergic to Latex, adhesive tape or betadine? ☐ **Yes** ☐ **No**

Do you see a doctor regularly for medical reasons? ☐ **Yes** ☐ **No**

Have you had any surgery in the past? ☐ **Yes** ☐ **No**

If yes, please list the date and type of surgery

Date	Name of Surgeon	Type of Surgery

Have you ever had a colonoscopy? ☐ **Yes** ☐ **No**

If yes, please list date and results:_____

Have you had any diseases or health problems in the past? ☐ **Yes** ☐ **No**

If yes please list.

Winfield Surgery & Services

CHRISTOPHER A. MORRISSEY, DO
GENERAL SURGERY

Patient Name: _____ Date of Birth: _____

MEDICATIONS/OVER THE COUNTER/SUPPLEMENTS

Do you take any prescribed medicine, over the counter, non-prescribed, or health supplements?

☐ **Yes** ☐ **No**

Are you currently taking any blood thinners (Warfarin/Coumadin, Aspirin, Xarelto/Rivaroxaban, Plavix/Clopidogrel, Prodaxa/Dabigatran? ☐ **Yes** ☐ **No**

List all medications prescribed and supplements you take.

Example: Multi-Vitamin 1 tab per day; Omeprazole 20 mg, 1 tab twice a day

Other information: Please write below any other information you feel the doctor should know.

_____ _____

Patient Signature **Date**

Winfield Surgery & Services
1230 E 6th Ave, Suite 2B
Winfield, KS 67156
www.winfieldsurgery.com