



**Pratt Healthcare
Department of Surgery
Dr. Henry Wicker
New Patient History Form**

Name _____ **DOB** _____

Marital status: (circle one) **S W D M** **Age** _____

Occupation _____ **Employer** _____

SS# _____

Home Address _____

Home# _____ **Cell#** _____ **Work#** _____

Pharmacy Name _____ **Phone #** _____

Whom may we thank for referring you here _____

Family History

Alive

Deceased

Cause of Death

Mother	_____	_____	_____
Father	_____	_____	_____
Sisters	_____	_____	_____
Brothers	_____	_____	_____

Circle if any of the following are found in immediate blood relative

Diabetes	Y or N	Who _____
High blood pressure	Y or N	Who _____
Cancer (what type)	Y or N	Who _____
Heart Disease	Y or N	Who _____
High Cholesterol	Y or N	Who _____

Social History

How much alcohol do you drink _____ (daily, occasional, etc.)

How much do you smoke daily _____ (Cigars, cigarettes, etc.)

Recreational Drugs _____ (marijuana, cocaine, etc.)

Medical History

If you are 50 and over, have you had colonoscopy? Yes ___ No ___

If yes, what year _____ Name of the Doctor _____

If you are under 50 years of age and have had a colonoscopy, please specify

Have you ever had a blood clot in your body? Yes ___ No ___

If Yes, what part of your body _____

Have you ever had broken bones? Yes ___ or No ___

What part of your body? _____

Did you have a **cast** or **splint**? _____

Do you have any pins or *screws* in your body? Yes ___ or No ___

If yes, What part of your body? _____

Please specify what side? _____ **Reason** _____

Do you have any heart condition? Yes ___ or No ___

If yes, list all your heart surgeries including stents _____

If yes, Who is your cardiologist? _____

When was your last visit? _____

Surgical History

Please circle one

Reason

Cataract(s) removed (L) or (R) eye or both
Repair of torn meniscus (L) or (R) knee or both
Repair of rotator cuff (L) or (R) shoulder or both _____
Knee Replacement (L) or (R) knee or both
Carpal tunnel (L) or (R) wrist or both
Hip Replacement (L) or (R) hip or both
Back or neck surgery _____

Repair of right inguinal hernia Y or N
Repair of left inguinal hernia Y or N
Repair of femoral hernia Y or N
Repair of umbilical hernia Y or N
Repair of abdominal hernia Y or N
Gastric Bypass (weight Loss surgery) Y or N
Lap band (weight loss surgery) Y or N
Laparoscopic Cholecystectomy (gallbladder) Y or N
Open Cholecystectomy (gallbladder) Y or N
Appendectomy Y or N
Hemicolectomy (colon surgery) _____ Y or N
Partial Hysterectomy--Reason: _____ Y or N
Total Hysterectomy—Reason: _____ Y or N
Tubal Ligation Y or N
Abdominoplasty Y or N
Tonsillectomy Y or N
Adenoidectomy Y or N
C- section (s) Y or N
Vasectomy Y or N
Prostatectomy Reason _____ Y or N

Please list any additional surgeries not listed in the list above.

Please circle your present and past illness

Tuberculosis	Thyroid disease	Nausea
HIV/AIDS	Diabetes High	Vomiting
Hepatitis	blood pressure	Indigestion
Liver trouble	Heart Problem	Heartburn Trouble
Jaundice	Reaction to	swallowing
Anemia	Anesthesia Stroke	Chronic cough
Bladder problem	Seizure Bleeding	
Kidney problem	Tendency	Spitting Blood

Please write or provide a list of current medication.

Are you allergic to any Medications, Iodine or Latex Y or N

If yes, what are you allergic to?

General health questions

Number of times you urinate at night _____

Last menstrual cycle _____

Number of pregnancies _____

Weight last year _____ Weight this year _____ Max.Weight _____