Jon F. Geers, MD

General Surgeon

188 State Road 129 S., Batesville, IN 47006

HEALTH QUESTIONNAIRE

Name: _____ Date: _____ Age: ____ Height: _____ Weight: _____

Family Physician: _____ Other Physician: _____

Why are you here to see Dr. Geers? _____

_____

Medications (include dosage): _____

_____

_____

Allergies: _____

Past Medical Problems: (Please check if you have had any of the following)

❒ Heart Attack (414.00)
❒ Angina (413.9)
❒ Arrythmia (427.9)
❒ Lung Disease (496)
❒ Asthma (439.9)
❒ Sleep Apnea (780.57)
❒ High Blood Pressure (401.9)
❒ Diabetes (250)
❒ Anemia (285.9)
❒ Kidney Failure (586)
❒ Acid Reflux (530.81)
❒ High Cholesterol (272)
❒ Thyroid Disease (244.9)
❒ Bleeding Disorder (286.9)
❒ Stroke (436)
❒ Seizures (780.39)
❒ Cancer
❒ Reaction to IV dyes/shellfish
❒ Claustrophobia
❒ Metal Implants
❒ Pacemaker Implant
❒ Defibrillator Implant
❒ Latex Allergy
❒ Other

If you checked any of the above, please briefly explain: _____

_____

_____

Please list any past surgeries you have had with the date of the surgery: _____

_____

_____

Immediate Family Medical History: (parents and siblings)

❒ Stroke
❒ Heart Attack
❒ Thyroid Disease
❒ Diabetes
❒ Gallbladder Disease
❒ High Blood Pressure
❒ Breast Cancer
❒ Colon Cancer
❒ Ovarian Cancer
❒ Other Cancer (specify)
_____
_____

(OVER)

HEALTH QUESTIONNAIRE

FEMALE PATIENTS ONLY:

Past Breast Problems: _____

Past Breast Surgery: _____

Date of last mammogram: _____ Where completed? _____

Number of children: _____ Did you breastfeed? ❒ Yes ❒ No Age at first delivery: _____

Do you take birth control pills or hormone replacement therapy? ❒ Yes ❒ No If yes, how many years? _____

Doctor Initials: _____ Date: _____

Which of the following symptoms are you currently having?

❒ Weight loss	❒ Rash	❒ Shortness of breath	❒ Diarrhea
❒ Poor appetite	❒ Joint pain	❒ Swollen glands	❒ Constipation
❒ Fatigue	❒ Breast pain	❒ Depression	❒ Heartburn
❒ Fever	❒ Breast lump	❒ Anxiety	❒ Jaundice
❒ Night sweats	❒ Nipple discharge	❒ Lethargy	❒ Pain with urination
❒ Headaches	❒ Coughing	❒ Abdominal pain	❒ Blood in stool
❒ Dizziness	❒ Wheezing	❒ Nausea	❒ Bloating
❒ Visual changes	❒ Chest pain	❒ Vomiting	❒ Lightheadedness

Other Symptoms: _____

_____

SOCIAL HISTORY:

Married: ❒ Yes ❒ No Number of Children: _____ Occupation: _____
Tobacco: ❒ Yes ❒ No Packs per day: _____ No. of years: _____
Alcohol: ❒ Yes ❒ No Drinks per week: _____
Caffeine: ❒ Yes ❒ No Cups per day: _____

When was your last chest X-ray? _____ Where? _____

When was your last EKG? _____ Where? _____

Doctor Initials: _____ Date: _____