GLACIAL RIDGE
HEALTH SYSTEM *heartfelt care*

BRIEF HISTORY

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name: First: Age: Sex: M F

Doctor Notes
Please do not write in this area.

Does your insurance plan cover preventative/wellness care? Yes No

Presenting Problem or Proposed Surgery:

ILLNESS/INJURY: Please check if you have ever had:

Yes	No		Yes	No	
		High blood pressure			Kidney Stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart Attack			Thyroid problem
		Chest pain/tightness			Lung problem/asthma
		History of heart murmur			Shortness of breath
		Stroke			Accidents/broken bones (list)
		Cancer			
		Hepatitis			
		Yellow jaundice			
		Gallstones			

OPERATIONS: List names and dates of all operations you have had ☐ None

Year	Name of Operation	Type of Anesthetic, if known	Complications

FAMILY HISTORY:

Are your parents living?
Mother: Yes No Cause of death: Age of death:
Father: Yes No Cause of death: Age of death:

Do you have a family history of:
Heart disease? Yes No Cancer? Yes No Diabetes? Yes No

Do you now use tobacco? Yes No Years of use__________

Have you ever used tobacco? Yes No Quit date_____________

Have you ever abused alcohol? Yes No Quit date_____________

Are you allergic to any medicine?

Other allergies?

The above information is true and accurate
Patient Signature (parent if patient is a minor)______________________________________
Date:__________________________