Welcome to the Medical Office of Warrett Kennard, M.D.

GENERAL & VASCULAR SURGERY | DIPLOMAR AMERICAN BOARD OF SURGERY | FELLOW AMERICAN COLLEGE OF SURGERY

Please fill your medical history to the best of your ability:

Patient Name: ____ Date of Birth: ___/___/____ Male or Female MRN: ___________

Age: __________ Height: _________ Weight: ___________ Primary Care Doctor: ____

History of Present Illness:

Chief Complaint ____

Location:____________________________ Quality:_____________________________ Severity:_____________________________
(Where is the pain/problem?) *(Ex. Normal vs abnormal color, activity, etc.)* *(How severe is the pain/problem on a scale 1-5, 5 being the most severe)*

Duration:____________ ______________ Timing:_____________________________ Context: ______________________________
(How long have you had this pain/problem or when did it start?) *(Does this pain/problem occur at a specific time?)* *(Where were you at the onset of this pain/problem?)*

Other Associated problems you have been having____

What makes the pain/problem worse or better and have you had previous episodes ____________________________

Current Medications *(including nonprescription)*: ____

____

Patient Medical History:

Have you ever had the following (Check "no" or "yes", leave blank if uncertain):

Condition	No	Yes	Condition	No	Yes	Condition	No	Yes	Condition	No	Yes
Measles	☐ No	☐ Yes	Anemia	☐ No	☐ Yes	High/Low Blood Pressure	☐ No	☐ Yes	Mitral Valve Prolapse	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Bladder Infections	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Chickenpox	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Whooping Cough	☐ No	☐ Yes	Migraines	☐ No	☐ Yes	Hives/Eczema	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes
Scarlet Fever	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Diphtheria	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Infectious Mono	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Smallpox	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes	Bleeding Tendency	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Polio	☐ No	☐ Yes	Date of last chest x-ray: ___/___/___			Back Trouble	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Persistent cough or throat			Any Other Disease (Please List) __________		
Heart Disease	☐ No	☐ Yes	Hernia	☐ No	☐ Yes	clearing not associated with			--		
Arthritis	☐ No	☐ Yes	Blood/Plasma	☐ No	☐ Yes	a known illness					
Venereal Disease	☐ No	☐ Yes	Transfusions	☐ No	☐ Yes	(for more than 3 weeks)	☐ No	☐ Yes			

Previous Surgeries/Illnesses/ Hospitalizations	Month/Year	Hospital, City, State/Prov.
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________
______________________________	__________	______________________________

Family Medical History:

	Age	Diseases	If deceased, cause and age of death
Father	__________	______________________________	______________________________
Mother	__________	______________________________	______________________________
Siblings	__________	______________________________	______________________________
	__________	______________________________	______________________________

Patient Social History:

Occupation: ______________________________

Sexual active: ☐Yes ☐No

Marital status: ☐Single ☐Married ☐Separated ☐Divorced Widowed

Use of alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of drugs: ☐Never ☐Type/frequency: ____

Use of tobacco: ☐Never ☐Previously, but quit ____ yr/mo/d ago ☐Current _______packs/day

Welcome to the Medical Office of Warrett Kennard, M.D.

GENERAL & VASCULAR SURGERY | DIPLOMAR AMERICAN BOARD OF SURGERY | FELLOW AMERICAN COLLEGE OF SURGERY

Review of Systems: Please indicate any personal history below.

Constitutional

Weight change (gain/loss) ☐ No ☐ Yes
Loss of appetite ☐ No ☐ Yes
Fever ☐ No ☐ Yes
Weakness ☐ No ☐ Yes
Bleeding problems ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes

Dermatology

Bruising ☐ No ☐ Yes
Rash ☐ No ☐ Yes
Moles ☐ No ☐ Yes
Lumps ☐ No ☐ Yes
Hx of flexural eczema ☐ No ☐ Yes
Dry/sensitive skin ☐ No ☐ Yes
Hives ☐ No ☐ Yes
Keloid formation ☐ No ☐ Yes
Acne ☐ No ☐ Yes
Skin cancer ☐ No ☐ Yes

Endocrinology

Excessive sweating ☐ No ☐ Yes
Polydipsia ☐ No ☐ Yes
Polyuria ☐ No ☐ Yes
Sleep disturbance ☐ No ☐ Yes
Cold intolerance ☐ No ☐ Yes
Heat intolerance ☐ No ☐ Yes

Hematology

Easy bleeding ☐ No ☐ Yes
Bruising ☐ No ☐ Yes
Swollen glands ☐ No ☐ Yes
Varicose veins ☐ No ☐ Yes

Neurology

Tremor ☐ No ☐ Yes
Headache ☐ No ☐ Yes
Tingling numbness ☐ No ☐ Yes
Seizures ☐ No ☐ Yes
Insomnia ☐ No ☐ Yes
Memory loss ☐ No ☐ Yes
Dizziness ☐ No ☐ Yes
Gait abnormality ☐ No ☐ Yes

Ophthalmology

Diminished vision ☐ No ☐ Yes
Eye irritation ☐ No ☐ Yes
Drainage from eyes ☐ No ☐ Yes
Blurring of vision ☐ No ☐ Yes
Seasonal eye irritation ☐ No ☐ Yes
Dander related eye ☐ No ☐ Yes
Loss of vision ☐ No ☐ Yes

ENT/Respiratory

Cold ☐ No ☐ Yes
Cough ☐ No ☐ Yes
Epistaxis ☐ No ☐ Yes
Hearing loss ☐ No ☐ Yes
Change in voice ☐ No ☐ Yes
Sore throat ☐ No ☐ Yes
Ringing in ears ☐ No ☐ Yes
Sinus pain ☐ No ☐ Yes

Cardiology

Leg pain ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes
Chest pain ☐ No ☐ Yes
Murmurs ☐ No ☐ Yes
Palpitations ☐ No ☐ Yes
Cyanosis ☐ No ☐ Yes
Edema ☐ No ☐ Yes
Varicose veins ☐ No ☐ Yes

Gastroenterology

Dysphagia ☐ No ☐ Yes
Water brash ☐ No ☐ Yes
Hemorrhoids ☐ No ☐ Yes
Crohn’s ☐ No ☐ Yes
Nausea ☐ No ☐ Yes
Heartburn ☐ No ☐ Yes
Vomiting ☐ No ☐ Yes
Difficulty swallowing ☐ No ☐ Yes
Abdominal pain ☐ No ☐ Yes
Diarrhea ☐ No ☐ Yes
Constipation ☐ No ☐ Yes
Change in bowel habits ☐ No ☐ Yes
Blood in stool ☐ No ☐ Yes

Musculoskeletal

Back pain ☐ No ☐ Yes
Joint stiffness ☐ No ☐ Yes
Joint pain ☐ No ☐ Yes
Joint swelling ☐ No ☐ Yes
Leg cramps ☐ No ☐ Yes
Sciatica ☐ No ☐ Yes
Fracture ☐ No ☐ Yes
Carpal tunnel ☐ No ☐ Yes

Psychology

Depression ☐ No ☐ Yes
Tension/stress ☐ No ☐ Yes
Sleep disturbances ☐ No ☐ Yes
Suicidal ideation ☐ No ☐ Yes
ADHD ☐ No ☐ Yes
Eating disorder ☐ No ☐ Yes
Mental/physical abuse ☐ No ☐ Yes
Anxiety ☐ No ☐ Yes

Genitourinary Male

Difficulty urinating ☐ No ☐ Yes
Increased urinary frequency ☐ No ☐ Yes
Potty trained ☐ No ☐ Yes
Hernia ☐ No ☐ Yes
Undescended testicle ☐ No ☐ Yes
Kidney disease ☐ No ☐ Yes
Hard testicle ☐ No ☐ Yes
Hypospadias ☐ No ☐ Yes
Retractile testicle ☐ No ☐ Yes

Genitourinary Female

Heavy periods ☐ No ☐ Yes
Difficulty urinating ☐ No ☐ Yes
Increased urinary frequency ☐ No ☐ Yes
Pelvic pain ☐ No ☐ Yes
Dysmenorrhea ☐ No ☐ Yes
Vaginal discharge ☐ No ☐ Yes
Hot flashes ☐ No ☐ Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to (Please circle if it is listed):

Penicillin or other antibiotics ☐ No ☐ Yes
Morphine, Demerol, or other narcotics ☐ No ☐ Yes
Novocain or other anesthetics ☐ No ☐ Yes
Iodine, merthiolate or other antiseptics ☐ No ☐ Yes

Other Allergies:
____
____
____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor’s office of changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature ____ Print Name ____ Date________________

Doctor’s Review: ____
____
____

Signature of Doctor _____________________________ Date _____________________