Surgeons of Northern Illinois

DATE: _____
PATIENT NAME: _____ **DATE OF BIRTH:** _____**Age:** _____

Office Use Only
Temp _____ BP _____ / _____ Pulse _____ Height _____ Weight _____ Taken by: _____

Past Medical History: Have you ever had the following: (Please √ all that apply)

Acid Reflux ☐	Blood Clots ☐	Heart Disease ☐	Migraine Headaches ☐
AIDS or HIV + ☐	Bronchitis/COPD ☐	Hemorrhoids ☐	Mitral Valve Prolapse ☐
Anemia ☐	Cancer ☐	Hernia ☐	Pneumonia ☐
Arthritis ☐	Chickenpox ☐	Hepatitis ☐	Rheumatic Fever ☐
Asthma ☐	Depression ☐	High Blood Pressure ☐	Sleep Apnea ☐
Bladder Infection ☐	Diabetes ☐	High Cholesterol ☐	Thyroid Disease ☐
Back Trouble ☐	Epilepsy/Seizures ☐	Hives or Eczema ☐	Tuberculosis ☐
Bleeding Tendency ☐	Glaucoma ☐	Kidney Disease ☐	Venereal Disease ☐

Are you on any blood thinners?: Yes ☐ No ☐ (If yes, please list)_____
Can you walk up a flight of stairs without stopping? Yes ☐ NO ☐

Prior Surgeries/Hospitalizations/Diseases	**When?**	**Hospital, City. State**
None ☐		
Appendix (appendectomy) ☐	_____	_____
Gallbladder (cholecystectomy) ☐	_____	_____
Uterus (hysterectomy) ☐	_____	_____
Bariatric surgery ☐	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: None ☐

	Please list dosage and frequency	Please list over-the-counter medications, Vitamins, Herbal supplements, etc.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY KNOWN DRUG ALLERGIES: None ☐

_____ **Reaction:** _____
_____ **Reaction:** _____
_____ **Reaction:** _____

Patient Social History:

Occupation: _____
Marital status: Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐
Use of alcohol: Never: ☐ Rarely: ☐ Moderate: ☐ Daily: ☐
Use of tobacco: Never: ☐ Previously, but quit: ☐ Current packs / day:_____, Approximate duration_____
Do you use street drugs? ☐ Yes ☐ No

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____
	___	_____	_____

HEALTH HISTORY

Review of Systems: Please indicate any personal history below:

CONSTITUTIONAL SYMPTOMS
- Good general health lately ☐
- Recent weight gain ☐
- Recent weight loss ☐
- Fatigue ☐
- Fever ☐

EYES
- Eye disease or injury ☐
- Wear glasses/contact lenses ☐
- Blurred or double vision ☐

EARS/NOSE/MOUTH/THROAT
- Mouth sores ☐
- Bleeding gums ☐
- Hearing loss or ringing ☐
- Chronic sinus problem ☐
- Nose bleeds ☐
- Sore throat or voice change ☐
- Swollen glands in neck ☐

CARDIOVASCULAR
- Abnormal EKG ☐
- Heart trouble ☐
- Chest pain angina pectoris ☐
- Palpitation ☐
- Shortness of breath w/ walking or lying flat ☐
- Swelling of feet, ankles or hands ☐
- Heart murmur ☐

RESPIRATORY
- Chronic or frequent coughs ☐
- Spitting up blood ☐
- Shortness of breath ☐
- Wheezing ☐
- Tuberculosis ☐
- Asthma ☐
- Emphysema ☐

GASTROINTESTINAL
- Loss of appetite ☐
- Change in bowel movement ☐
- Nausea or vomiting ☐
- Frequent diarrhea ☐
- Painful bowel movements ☐
- Gallbladder problems ☐
- Rectal bleeding ☐
- Blood in stool ☐
- Hemorrhoids ☐
- Abdominal pain ☐
- Gastric Reflux ☐

GENITOURINARY
- Frequent urination ☐
- Burning or painful urination ☐
- Blood in urine ☐
- Change in force of stream when urinating ☐
- Incontinence or dribbling ☐
- Kidney stones ☐
- Sexual difficulty ☐
- Male – testicle pain ☐
- Female – pain with periods ☐
- Female – irregular periods ☐
- Female – vaginal discharge ☐
- Female - # of pregnancies _____
- Female - # of miscarriages _____
- Female – date of last pap smear _____
- Date of last menstrual period _____

MUSCULOSKELETAL
- Joint pain or stiffness ☐
- Difficulty in walking ☐
- Muscle weakness ☐
- Muscle pain or cramps ☐
- Back pain ☐
- Cold extremities ☐

INTEGUMENTARY (skin)
- Rash or itching ☐
- Change in skin color ☐
- Change in hair or nails ☐
- Varicose veins ☐

BREAST
- Breast pain ☐
- Breast lump ☐
- Nipple discharge ☐
- Date of last mammogram _____
- Date of Breast Biopsy _____
- Breast Rash ☐

NEUROLOGICAL
- Head injury ☐
- Light headed or dizzy ☐
- Convulsions or seizures ☐
- Numbness or tingling sensations ☐
- Stroke or mini-stroke ☐
- Tremors ☐
- Paralysis ☐
- Headaches ☐

PSYCHIATRIC
- Memory loss or confusion ☐
- Nervousness ☐
- Depression ☐
- Insomnia ☐
- Suicidal thoughts ☐
- Violent or Unusual thoughts ☐

ENDOCRINE
- Glandular or hormone prob ☐
- Excessive thirst or urination ☐
- Heat or cold intolerance ☐
- Skin becoming drier ☐
- Thyroid problems or goiter ☐

HEMATOLOGIC/LYMPHATIC
- Enlarged glands ☐
- Slow to heal after cuts ☐
- Bleeding or bruising tendency ☐
- Anemia ☐
- Phlebitis/Blood clots ☐

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
- Penicillin ☐
- Other Antibiotics _____ ☐
- Novocain ☐
- Other Anesthetics _____ ☐
- Aspirin ☐
- Other pain remedies _____ ☐
- Iodine ☐
- Morphine ☐
- Demerol ☐
- Other narcotics _____ ☐

Known food Allergies: _____

_____

Anesthesia problems: _____

_____

Environmental allergies: _____

_____

LATEX ALLERGY ☐

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 any changes in my medical status.

Signature of Patient or Guardian_____ Date: _____

Signature of Doctor_____ Date: _____