

*Surgeons of Northern Illinois*

Welcome to our practice. As a new or existing patient presenting with a new problem, please fill out the information to the best of your ability.

**ACCT #** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Office Use Only**

**Temp** \_\_\_\_\_ **BP** \_\_\_\_\_ / \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Taken by:** \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Where is the pain/problem? \_\_\_\_\_  
How severe is the pain/problem on a scale of 1-5 with 5 being the most severe? 1 2 3 4 5 (please circle your choice)  
Does the pain/problem occur at a specific time? \_\_\_\_\_  
What makes the pain/problem worse or better? \_\_\_\_\_  
Referring Physician: \_\_\_\_\_

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

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

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**

	<b>When?</b>	<b>Hospital, City, State</b>
None <input type="radio"/>		
Appendix (appendectomy) <input type="radio"/>	_____	_____
Gallbladder (cholecystectomy) <input type="radio"/>	_____	_____
Uterus (hysterectomy) <input type="radio"/>	_____	_____
_____ <input type="radio"/>	_____	_____
_____ <input type="radio"/>	_____	_____

**Medications:** None

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

**LIST ANY KNOWN DRUG ALLERGIES:** None

_____	<b>Reaction:</b> _____
_____	<b>Reaction:</b> _____
_____	<b>Reaction:</b> _____

**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	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT NAME: \_\_\_\_\_

**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: \_\_\_\_\_