OSF MEDICAL GROUP GENERAL SURGERY
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Please complete all forms ***before*** *your appointment. Make sure to bring all medications with you.*

PATIENT HISTORY FORM

MEDICAL HISTORY

Name____ **Date of Birth**_________________

Reason for Seeking Medical Attention____

Current Illnesses/Medical Conditions:

________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________

List all physicians you are currently seeing:	**Last visit?**	***City/State/Phone***
____________________________________	__________	____________________
____________________________________	__________	____________________
____________________________________	__________	____________________
____________________________________	__________	____________________

Previous Surgeries/Hospitalizations/Serious Illnesses	***What year?***	***Hosp./City/State***
______________________________________	_________	____________________
______________________________________	_________	____________________
______________________________________	_________	____________________
______________________________________	_________	____________________
______________________________________	_________	____________________
______________________________________	_________	____________________

SOCIAL HISTORY

Employment Status: __Employed __Self-Employed __Retired __Unemployed __Disabled ___ Student

Employer and occupation: ____

Where do you currently reside? ___ Independently ___ Assisted Living Facility ___ Nursing Home

Marital Status: __Single __Married __Separated __Divorced __Widowed

Use of Alcohol:

Current ___No ___Yes if Yes, number of drinks per week ____________________

Past ___No ___Yes if Yes, number of drinks per week ____________________

Use of Tobacco:

Current ___No ___Yes if Yes, number of packs per day _____ Number of years_____

Past ___No ___Yes if Yes, when did you quit? ____________________

Do you use illegal/street drugs? ☐ Yes ☐ No If so, what do you use?____________________

Do you have a religious affiliation that would affect decisions about your care? ☐ Yes ☐ No

If yes, please explain____

Do you have a: ☐ Living Will ☐ Healthcare Power of Attorney ☐ Do not Resuscitate Order ☐ None

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father	_______	____________________________	______________________
Mother	_______	____________________________	______________________
Siblings	_______	____________________________	______________________
	_______	____________________________	______________________
	_______	____________________________	______________________
Spouse	_______	____________________________	______________________
Children	_______	____________________________	______________________
	_______	____________________________	______________________
	_______	____________________________	______________________

Name______________________________ **Date of Birth**__________________

FOR WOMEN ONLY

At what age did you begin menstruation?______________________________
What was the date of your last menstrual period?______________________________
How many times have you been pregnant?______________________________
How many children do you have?______________________________
How old were you at the birth of your first child? ________ Did you ever breastfeed?______________
Do you still have menstrual periods? If not, at what age did you stop?______________________
Do you use birth control or hormone therapy? If so, please list the type______________________
Is there a family history of breast cancer?______________________________
If over the age of 35, when was your last mammogram?______________________________

MEDICATIONS

Do you have any allergies to medications? Yes ____ No____
Please List all Medication allergies and reactions: ______________________________

____

Are you allergic to Latex, rubber gloves, rubber bands, or balloons? Yes ____ No____
Do you require antibiotics before surgery or dental procedures? Yes ____ No____

Please list your current medications, vitamins, and herbal supplements (or give receptionist a printed list to copy)

Medication	Reason you take	Dosage&Times per day	Prescribing Doctor

Name____ **Date of Birth**__________________

Patient Medical History & Review of Systems

Please indicate any personal history below, past or present

Constitutional Systems

Recent weight change ____No ___Yes
Loss / Gain # of pounds ________
Fever ___No ___Yes
Eye disease or cataracts ___No ___Yes
Wear glasses/contact lenses ___No ___Yes
Blurred or double vision ___No ___Yes
Glaucoma ___No ___Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing ___No ___Yes
Chronic sinus problems ___No ___Yes
Nose bleeds ___No ___Yes
Sore throat or voice change ___No ___Yes

Cardiovascular

Heart murmur ___No ___Yes
Mitral valve prolapse ___No ___Yes
Rheumatic fever ___No ___Yes
High or low blood pressure ___No ___Yes
On blood pressure medication ___No ___Yes
Chest pain or angina pectoris
In the last 30 days ___No ___Yes
Palpitation ___No ___Yes
Congestive Heart Failure ___No ___Yes
Pacemaker / AICD ___No ___Yes
Irregular pulse ___No ___Yes
History of heart attack ___No ___Yes
When? __________________
Swelling of feet, ankles or hands ___No ___Yes
Heart disease ___No ___Yes
Coronary angiogram ___No ___Yes
When? _________________
Heart surgery ___No ___Yes
When? _________________
Peripheral Vascular Disease ___No ___Yes

Respiratory

Chronic or frequent coughs ___No ___Yes
Emphysema or COPD ___No ___Yes
Asthma ___No ___Yes
Bronchitis ___No ___Yes
Tuberculosis or positive TB test ___No ___Yes
Shortness of breath
While walking or lying flat ___No ___Yes
Wheezing ___No ___Yes
Pneumonia ___No ___Yes
Spitting up blood ___No ___Yes
Sleep apnea ___No ___Yes

Gastrointestinal

Abdominal Pain ___No ___Yes
Esophageal Varices ___No ___Yes
Nausea or vomiting ___No ___Yes
Frequent diarrhea ___No ___Yes
Change in bowel movement ___No ___Yes
Painful bowel movements
or constipation ___No ___Yes
rectal bleeding or
blood in stool ___No ___Yes
Stomach ulcer ___No ___Yes
Vomiting blood ___No ___Yes
History of liver disease ___No ___Yes
Jaundice ___No ___Yes
Hepatitis ___No ___Yes
Hemorrhoids ___No ___Yes
Date of last colonoscopy _____________

Genitourinary

frequent urination ___No ___Yes
burning or painful urination ___No ___Yes
Blood in urine ___No ___Yes
Change in force of stream
when urinating ___No ___Yes
Incontinence or dribbling ___No ___Yes
Kidney stones ___No ___Yes
Males – testicle pain ___No ___Yes
Males – Date of last PSA? ____________
Females – Date of LMP ____________
Females - Hysterectomy or tubal ligation?

Musculoskeletal

Joint pain ___No ___Yes
Weakness of muscles/joints___No ___Yes
Muscle pain or cramps ___No ___Yes
Back pain ___No ___Yes
Cold extremities ___No ___Yes
How far can you walk without pain? ______
Pain while at rest ___No ___Yes
Arthritis ___No ___Yes
Hernia ___No ___Yes

Integumentary (skin, breast)

Rash or itching ___No ___Yes
Change in skin color ___No ___Yes
varicose veins ___No ___Yes
Breast pain ___No ___Yes
Breast lump ___No ___Yes
Breast discharge ___No ___Yes
Date of last mammo? _______________

Psychiatric

Memory Loss or confusion ___No ___Yes
Nervousness ___No ___Yes
Depression ___No ___Yes
Insomnia ___No ___Yes

Neurological

Frequent or recurring headaches ___No ___Yes
Light headed or dizzy ___No ___Yes
Convulsions or seizures ___No ___Yes
Numbness/tingling sensation ___No ___Yes
Tremors ___No ___Yes
Paralysis ___No ___Yes
Head injury ___No ___Yes
Stroke (RIND or TIA) ___No ___Yes
Migraine headaches ___No ___Yes
Brain tumor ___No ___Yes

Endocrine

Prescription steroid use ___No ___Yes
Glandular or hormone problems ___No ___Yes
Excessive thirst or urination ___No ___Yes
Heat or cold intolerance ___No ___Yes
Diabetes ___No ___Yes
on diabetic medication or insulin?
Thyroid disease ___No ___Yes
Kidney disease ___No ___Yes
Kidney failure ___No ___Yes
Hemo Dialysis or CAPD ___No ___Yes

Hematologic/Lymphatic

Slow to heal after cuts ___No ___Yes
Bleeding or bruising tendency ___No ___Yes
Anemia ___No ___Yes
Phlebitis or blood clots in legs ___No ___Yes
Past transfusion-blood/plasma ___No ___Yes
Enlarged glands ___No ___Yes
Cancer ___No ___Yes
Chemo or radiation ___No ___Yes
HIV+ ___No ___Yes

Date & location of most recent bloodwork
____

Date & location of most recent EKG
____

Date & location of most recent chest X-ray
____

Authorization and 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 any changes in my medical status.

____ _________________________

Signature of patient (or legal representative and relationship) Date