Oaklawn

PLEASE FILL OUT FORM COMPLETELY

OMG GENERAL SURGICAL ASSOCIATES

HEALTH HISTORY (Confidential)

Name: _____ Today's Date _____

Age: _____ Date of Birth: _____What is your reason for visit? _____

MUST BE COMPLETED BY PATIENT OR PARENT/GUARDIAN (if minor child)

SOCIAL HISTORY Please circle

1. Primary Language: _____English _____Other _____. Translator needed? Yes No
2. Do you drink alcohol? Yes No How much? _____ How long? _____ If in past, when quit? _____
3. Do you drink Caffeine? Yes No How much? _____ How long? _____ If in past, when quit? _____
4. Do you or have you taken any drugs other than prescription medications? Y N What Kind? _____ When? _____
5. Employment Status: Full Time Part Time Student Unemployed Retired Disabled Self-Employed
6. Marital status: Married Divorced Widowed Single
7. Does your work require heavy lifting? Yes No If yes, explain _____
8. Are you exposed to hazardous substances at work? Yes No If yes, explain _____
9. Do you experience stress related to your work? Yes No If yes, explain _____
10. # of pregnancies? _____ Complications? _____ Are you currently pregnant? Y N How far along? _____
11. Do you smoke/chew tobacco? Yes No How much? _____ How Long? _____ If in past, when quit? _____
12. Do you use marijuana? Yes No How much? _____How Long? _____If in past, when quit? _____

FAMILY HISTORY

Please check if any **blood** relative have had or currently have any of the following:

☐ Arthritis Who: _____ ☐ Heart Disease Who: _____

☐ Lung Disease Who: _____ ☐ Stroke Who: _____

Type: _____ ☐ High Blood Pressure Who: _____

☐ Cancer Who: _____ ☐ Kidney Disease Who: _____

Type: _____ Type: _____

☐ Diabetes Who: _____ ☐ Tuberculosis: Who: _____

☐ Other _____ Who: _____

PERSONAL MEDICAL HISTORY—Please check any condition you as the patient have had during your lifetime.

☐ AIDS/HIV	☐ Chemical Dependency	☐ Heart Disease ☐ Valve Disorder	☐ Nausea/Vomiting with anesthesia
☐ Acid Reflux	☐ Chest Pain	☐ Herpes: Type_____	☐ Numbness in extremities
☐ Alcoholism	☐ Cirrhosis/Hepatitis: Type _____	☐ High Blood Pressure	☐ Pacemaker/Defibrillator
☐ Anemia	☐ COPD	☐ High Cholesterol	☐ Pneumonia
☐ Appendicitis	☐ Congestive Heart Failure	☐ Irregular Heart Beat	☐ Peripheral Vascular Disease
☐ Arthritis: Type_____	☐ Dentures/lose/damaged teeth	☐ Kidney Disease: Type ____	☐ Prostate Problem
☐ Asthma	☐ Diabetes: Type_____	Dialysis Y N	☐ Recent Hospitalization: Date_____
☐ Bleeding Disorders	☐ Difficult Intubation	☐ Liver Disease	☐ Rheumatologic Problem
☐ Blood Clot	☐ Emphysema	☐ Lung Disease	☐ Seizure
☐ Blood thinning Medications	☐ Epilepsy	☐ Malignant Hyperthermia	☐ Sleep Apnea ☐ CPAP ☐ BiPAP
☐ Bronchitis(frequent)	☐ Glaucoma	☐ Mental Impairment: Type_____	☐ Thyroid Problem
☐ Cancer: Type _____	☐ Goiter	☐ Migraine Headache	☐ Tuberculosis
☐ Cardiac Stents: Date_____	☐ Hard of hearing	☐ Multiple Sclerosis	☐ Ulcers
☐ Cataracts	☐ Heart Attack: Date_____	☐ Muscle/Nerve Damage	☐ Vaginal Infections/Venereal Disease

Have you ever had a blood transfusion? Yes No When? _____

ALLERGIES To medications or substances

Name of medication or Substance	Reaction when taken or come into contact with:
_____	_____
_____	_____
_____	_____
_____	_____

X-RAY DYE: YES NO Reaction: _____

LATEX ALLERGY: YES NO Reaction: _____

Name of Local Pharmacy: _____

Name of Mail Order Pharmacy: _____

Name: _____
Date of Birth: _____

SURGICAL HISTORY-List Entire History

DATE	HOSPITAL	PROCEDURE PERFORMED

REVIEW OF SYSTEMS-Currently or within last year

GENERAL
- ☐ Chills
- ☐ Sweats
- ☐ Fever
- ☐ Depression
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness

Neurological
- ☐ Headache
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Dizziness
- ☐ Numbness

MUSCULOSKELETAL
(pain, weakness, numbness in)
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

SKIN
- ☐ Bruise Easily
- ☐ Itching
- ☐ Change in Moles
- ☐ Sore that won't heal
- ☐ Hives
- ☐ Rash
- ☐ Scars

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose Veins

EYES, EARS, NOSE, THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Contact Lenses/Glasses
- ☐ Crossed Eyes
- ☐ Dentures/Partials
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision—flashes
- ☐ Vision—halos

RESPIRATORY
- ☐ Chronic Cough
- ☐ Productive Cough
- ☐ Bloody Cough
- ☐ Wheezing
- ☐ Shortness of Breath

MEN only
- ☐ Breast Lump
- ☐ Erection difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Other _____

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful intercourse
- ☐ Vaginal Discharge
- ☐ Other _____

Date of last menstrual period _____

Date of last Pap Smear _____

Date of last Mammogram _____

Date of Flu Vaccination _____

Date of Pneumonia Vaccination: _____

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS

You may skip this section if **LEGIBLE** list with dosage information provided at registration.

MEDICATIONS	MG	HOW MANY TIMES PER DAY?

Do you take any of these medications daily: Aspirin, Plavix, Coumadin, Warfarin, or other Anti-Coagulants _____?

Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor(s) or any members of his/her staff responsible for any error or omissions that I may have made in the completion of this form.

_____ _____
Patient/Guardian Signature Date

_____ _____
Physician Signature Date