

PHYSICIANS' SURGICAL CENTER 311 W. Lincoln, Ste. 300, Belleville, IL 62220

Medical History Information

Name _____ DOB _____ Surgery Date _____

First MI Last
Height _____ Weight _____ Reason for Surgery _____ with Dr. _____

Allergies to Medications, Foods, Metals, Tape and Latex? _____

Current Medications/Herbs/Supplements/OTC Meds – How often & Dosage (Continue on back of form if necessary)

Past Surgeries, Hospitalizations & Dates (Continue on back of form if necessary)

Do You Have: A Pacemaker/Defibrillator yes no

Artificial Heart Valve? yes no

What is Your Social History?

Do you smoke? _____ How many packs per day? _____ For how many years? _____ Date Quit _____

Do you drink alcohol? _____ How many drinks per day? _____ per week? _____ per month? _____ Substance Use? _____

Family Medical History

Heart Disease (heart attack, heart failure)? yes no Stroke? yes no Diabetes yes no

High Blood Pressure? yes no History of Cancer? yes Site _____ Colon Cancer? _____

Family Member having any complications other than nausea or vomiting with anesthesia? Yes No

Please check and circle any that apply to you:

- Blood/Lymph problems (anemia, bleeding disorders) Ever had blood transfusion? If yes, when? _____
- Complications other than nausea or vomiting with anesthesia? If yes, explain _____
- Dentures/Caps/Bridgework/Partials? Where in your mouth? _____
- Diabetes
- Ears, Nose, Throat (difficult, painful swallowing, ear aches, sinus problems, allergies, recent cough, cold, flu)
- Eyes (glaucoma, glasses, contacts)
- Heart/Circulation (heart attack, heart failure, chest pain, high blood pressure, palpitations, mitral valve prolapse)
- High Cholesterol
- Implants or prosthesis? Where? _____
- Kidney Disease
- Liver Disease/Hepatitis/Jaundice
- Lungs/Breathing (shortness of breath, asthma, frequent cough, emphysema/COPD)
- Muscles/Joints/Bones (osteoporosis, arthritis, injury) Where? _____
- Neurological (seizures, paralysis, headaches, numbness, stroke, TIA)
- Pneumonia, TB, or abnormal chest x-ray? Explain _____
- Psychiatric (Depression, Anxiety, Bi-Polar)
- Reproductive/Urinary
- Skin (rashes, itching) Body Piercing? Where? _____
- Sleep apnea (excessive snoring, awakening during the night, use of CPAP or BIPaP machine)
- Thyroid/Endocrine
- Ulcer Disease, GERD, Hiatal Hernia
- Weight gain/loss
- Other Chronic Illnesses/Cancer? Explain _____

Females: Date Last Menstrual Period _____ Are you pregnant? Yes No

Name of Person who will take you home and help after discharge _____

Do you have an Advanced Directive (Living Will)? Yes No If No, would you like information? Yes No