

Patient History (1 of 3)

Personal History

Weight _____ Height _____
 Do you take aspirin daily? Yes No Do you have a heart murmur? Yes No
 Are you allergic to LATEX? Yes No Do you have Sleep Apnea? Yes No
 Do you take blood thinners? Yes No (ASA, Plavix, Coumadin, Agranox, etc.)

Previous Operations (Next to your previous operation, write-in your *age* at which time the surgery was done)

AGE		AGE		AGE	
<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Knee arthroscopy	<input type="checkbox"/>	Bladder scope
<input type="checkbox"/>	Appendix	<input type="checkbox"/>	Knee replacement	<input type="checkbox"/>	Prostate surgery
<input type="checkbox"/>	Gallbladder	<input type="checkbox"/>	Plates/screws for fracture	<input type="checkbox"/>	Lithotripsy
<input type="checkbox"/>	Melanoma removal	<input type="checkbox"/>	Hip replacement surgery	<input type="checkbox"/>	Wisdom teeth
<input type="checkbox"/>	Bowel obstruction/adhesions	<input type="checkbox"/>	Bunions	<input type="checkbox"/>	Stomach ulcer
<input type="checkbox"/>	Colonoscopy	<input type="checkbox"/>	Heart valve surgery	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	Colon Cancer surgery	<input type="checkbox"/>	Leg bypass surgery	<input type="checkbox"/>	Tonsils
<input type="checkbox"/>	Diverticulitis surgery	<input type="checkbox"/>	Coronary artery bypass	<input type="checkbox"/>	Nose repair
<input type="checkbox"/>	Other colon surgery	<input type="checkbox"/>	Carotid artery surgery	<input type="checkbox"/>	Ear tubes
<input type="checkbox"/>	Hemorrhoid surgery	<input type="checkbox"/>	Aortic aneurysm repair	<input type="checkbox"/>	Mastectomy
<input type="checkbox"/>	C-section	<input type="checkbox"/>	Pacemakers	<input type="checkbox"/>	Breast implants
<input type="checkbox"/>	D and C	<input type="checkbox"/>	Cardiac stents	<input type="checkbox"/>	Breast biopsy
<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Internal Defibrillator	<input type="checkbox"/>	Plastic surgery
<input type="checkbox"/>	Ovaries removed (yes/no)	<input type="checkbox"/>	Angioplasty		


Other _____

Past Medical History (place an X in the box next to your associated medical conditions)

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Crohn's disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Hyperthyroid (high level)
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hypothyroid (low level)
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>	Breast cancer
<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Colon cancer
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	Uterine cancer
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	Stomach ulcer	<input type="checkbox"/>	Skin cancer
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>	Prostate cancer
<input type="checkbox"/>	Abnormal heart rhythm	<input type="checkbox"/>	Enlarged prostate	<input type="checkbox"/>	Lung cancer
<input type="checkbox"/>	Heart valve damage	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>	Mouth cancer
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	Thyroid cancer
<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Other cancer
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Radiation treatment

Other _____

Patient Signature _____ Physician Signature _____

 **Naperville Surgical Associates, Ltd.**
10 W. Martin Ave., Ste. 225
Naperville, IL 60540
(630) 355-5633 (630) 355-5215 Fax

--patient label--

Patient History (3 of 3)

Constitutional:

Do you have fatigue?	Yes	No
Do you have fibromyalgia?	Yes	No
Do you have weight loss?	Yes	No

Eyes:

Have your eyes turned yellow?	Yes	No
Have you ever lost vision?	Yes	No
Other issues with your eyes?	Yes	No

Cardiac:

Do you have chest pain?	Yes	No
Do you have palpitations?	Yes	No
Shortness of breath climbing stairs?	Yes	No
Other issues with your heart?	Yes	No

Genitourinary:

Do you get urinary infections?	Yes	No
Do you have blood in the urine?	Yes	No
Pain/burning when you urinate?	Yes	No
Other urinary issues?	Yes	No

Neurologic:

Have you had seizures or epilepsy?	Yes	No
Do you have multiple sclerosis?	Yes	No
Have you had a major head injury?	Yes	No
Other neurologic issues?	Yes	No

Vascular:

Any problems with blood vessels?	Yes	No
Any known narrowing of vessels?	Yes	No
Other circulation issues?	Yes	No

Endocrine:

Do you take steroids?	Yes	No
Hormone supplements?	Yes	No
Any hormonal abnormalities?	Yes	No

Musculoskeletal:

Do you have Gout?	Yes	No
Spinal disc problem?	Yes	No
Disorder of bone/muscle?	Yes	No

Anesthesia:

Prior problems with anesthesia?	Yes	No
Family with malignant hyperthermia?	Yes	No
Prior alerts or warnings re: anesthesia?	Yes	No

Head, ears, nose, throat and neck:

Any chronic sinus problems?	Yes	No
Any lumps or bumps in the neck?	Yes	No
Any new skin lesions or moles?	Yes	No
Other issues with your head, ears, nose throat or neck?	Yes	No

Lungs:

Are you on home oxygen?	Yes	No
Any lung problems not being treated?	Yes	No
Any severe shortness of breath?	Yes	No
Other issues with your lungs?	Yes	No

Gastrointestinal:

Do you have diarrhea?	Yes	No
Do you have constipation?	Yes	No
Do you have blood in the stool?	Yes	No
Do you have black stool?	Yes	No
Do you have mucus in the stool?	Yes	No
Do you have narrowing of the stool?	Yes	No
Other intestinal issues?	Yes	No

Psychiatric:

Are you bipolar?	Yes	No
Other psychiatric issues?	Yes	No

Hematologic:

Bleeding problems or tendencies?	Yes	No
Prior abnormal blood clots?	Yes	No
Sickle cell disease?	Yes	No
Inheritable blood disease?	Yes	No
Abnormal blood counts?	Yes	No

Patient Signature _____

Physician Signature _____



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