PATIENT HISTORY

DuPage Surgical Consultants

Name: ______________________ **Date:** ______________
Date of birth: ______________ **Height:** ______________ **Weight:** ______________
Occupation: ______________________
Primary care or referring doctor: ______________________
Reason for today's visit: ______________________

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Routine Medications:

Name:	Dosage:	Name:	Dosage:

Herbal Medications (you are currently taking):

- ☐ Kava
- ☐ Garlic
- ☐ Ginseng
- ☐ Ephedra
- ☐ Ginko
- ☐ St. John's Wort
- ☐ Echinacea
- ☐ Valerian
- ☐ Other______________

ALLERGIES & DRUG REACTIONS YOU HAVE/HAD: ☐ **NONE** ☐ **YES, Please explain**

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Medical history: (check the conditions you have/had)

- ☐ stroke
- ☐ seizures
- ☐ eyes disorders
- ☐ ears disorders
- ☐ nose disorders
- ☐ mouth disorders
- ☐ thyroid disorders
- ☐ heart attack
- ☐ chest pain
- ☐ high blood pressure
- ☐ shortness of breath
- ☐ emphysema
- ☐ asthma
- ☐ ulcer
- ☐ reflux or heartburn
- ☐ jaundice
- ☐ hepatitis
- ☐ gallbladder problems
- ☐ colitis
- ☐ diarrhea
- ☐ constipation
- ☐ rectal bleeding
- ☐ kidney disorders
- ☐ bladder problems
- ☐ arm problems
- ☐ leg problems
- ☐ diabetes
- ☐ adrenals disorders
- ☐ skin conditions
- ☐ cancer (please specify) ______________
- ☐ anemia
- ☐ bleeding problems
- ☐ HIV/AIDS
- ☐ positive for TB
- ☐ Other:______________

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DATE	TYPE OF OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD

______________________________ **M.D.**

PATIENT HISTORY (cont.)

Transfusions or problems with anesthesia? ☐ **NO** ☐ **YES, Please explain:**

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Obstetrics and Gynecology:

No. of pregnancies ____________ No. of births ____________

Last menstrual period __________________

Any difficulties? ______________________________________

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Family history: Please list any significant medical history for the relatives indicated below:
(ie., cancer, hypertension/ high blood pressure, endocrine disorders, etc....)

Mother ______________________________________

Father ______________________________________

Sister ______________________________________

Brother ______________________________________

Other ______________________________________

Habits: Please check all that apply.

☐ Tobacco if yes, how many packs/day_______ for how many years______________

☐ Coffee if yes, how much/day______________________________

☐ Alcohol if yes, how much______________________________

☐ Drugs if yes, please specify______________________________

Please use this space to clarify any answers if necessary:

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