SURGICAL CONSULTANTS OF DUPAGE
PATIENT HEALTH HISTORY

Patient ______________________ Age ________ Birthdate ____________

HISTORY OF PRESENT ILLNESS:

What is your current surgical problem? ______________________

What symptoms are you having? For how long? ______________________

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PREVIOUS SURGERIES: (date)

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OTHER MEDICAL PROBLEMS: (diabetes, high blood pressure, heart disease, etc.)

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PERSCRIPTION MEDICATIONS: Name/Dose/Frequency

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OVER THE COUNTER MEDS: (aspirin, herbals, vitamins)_

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ALLERGIES: Medication/Food, etc. and reaction if any

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SOCIAL HISTORY: Occupation: ____________ Marital Status: ________ Number of children: ____

Tobacco Yes _____ No _____ How much/how often? ______________________

Alcohol Yes _____ No _____ How much/how often? ______________________

Drugs Yes _____ No _____ How much/how often? ______________________

FAMILY MEDICAL HISTORY: (Mother, Father, Sister, Brother)

RELATIONSHIP	AGE	DISEASES

BREAST HISTORY (if applicable):

Age at first menstrual period ________ Age at menopause ________

Age at first pregnancy ________ Number of pregnancies ________

Did you breastfeed? ________ Date of last menstrual period ________

History of hormone use (i.e. estrogen, oral contraceptives) ______________________

Relatives with breast disease ______________________

AUTHORIZATION: To the best of my knowledge, the questions on this form have been accurately answered to the best of my ability. It is my responsibility to inform the medical office of any changes in my medical status.

______________________ ______________

Signature of Patient/Guardian if minor Date

DOCTOR REVIEW

______________________ ______________

Physician Signature Date

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REVIEW OF SYSTEMS

Please indicate any personal history below.

General	Yes	No
Good general health lately	☐	☐
Recent weight change	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Headaches	☐	☐
Eyes		
Eye disease or injury	☐	☐
Wear glasses/contact lenses	☐	☐
Blurred or double vision	☐	☐
Ear, Nose, Mouth, Throat		
Hearing loss or ringing	☐	☐
Earaches or drainage	☐	☐
Chronic sinus problems	☐	☐
Nose bleeds	☐	☐
Bleeding gums	☐	☐
Bad breath or bad taste in mouth	☐	☐
Sore throat	☐	☐
Laryngitis	☐	☐
Swollen glands in neck	☐	☐
Cardiovascular/Heart		
Heart trouble	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Swelling of feet, ankles, hands	☐	☐
Respiratory		
Chronic or frequent coughs	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Gastrointestinal		
Loss of appetite	☐	☐
Change in bowel movements	☐	☐
Nausea or vomiting	☐	☐
Frequent diarrhea	☐	☐
Painful bowel movements	☐	☐
Blood in stools	☐	☐
Constipation	☐	☐
Rectal bleeding	☐	☐
Abdominal pain	☐	☐

Genitourinary	Yes	No
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Change in force or stream when urinating	☐	☐
Incontinence or dribbling	☐	☐
Kidney stones	☐	☐
Sexual difficulty	☐	☐
Male - testicular pain	☐	☐
Female - pain with periods	☐	☐
- irregular periods	☐	☐
- vaginal discharge	☐	☐
Musculoskeletal		
Joint pain	☐	☐
Joint stiffness or swelling	☐	☐
Weakness of muscles or joints	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Cold extremities	☐	☐
Difficulty in walking	☐	☐
Skin		
Rash or itching	☐	☐
Change in skin color	☐	☐
Change in hair or nails	☐	☐
Varicose veins	☐	☐
Neurological		
Frequent or recurring headaches	☐	☐
Lightheaded or dizzy	☐	☐
Convulsions or seizures	☐	☐
Numbness or tingling	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Head injury	☐	☐
Endocrine		
Glandular or hormone problem	☐	☐
Excessive thirst or urination	☐	☐
Heat or cold intolerance	☐	☐
Skin becoming drier	☐	☐
Change in hat or glove size	☐	☐
Hematologic/Lymphatic		
Slow to heal after cuts	☐	☐
Bleeding or bruising	☐	☐
Anemia	☐	☐
Phlebitis	☐	☐
Past transfusion	☐	☐
Enlarged glands	☐	☐