

Today's Date _____

Date Updated _____

**Surgery Group
OF GRAND ISLAND**

Legal Name _____

Date of Birth _____

Review of Systems

Please check all that apply, both currently and in your past

Constitutional	Eyes and Head	Endocrine	Neurological
Appetite Change	Vision Change	Diabetes	Epilepsy
Weight Change	Headaches	Thyroid Problem	Palsy
Fever	Dizziness	Muscle/Skeletal	Stroke
Chills	Respiratory	Arthritis	Speech
Malaise	Shortness breath	Bursitis	Tingling
Fatigue	Cough	Gout	Psychiatric
Jaundice	Wheezing	Osteoporosis	Anxious
Skin	Pneumonia	Back Pain	Depressed
Itching	Gastrointestinal	Circulatory	Other
Rash	Indigestion	High Blood Pressure	Breast mass
Hives	Nausea	Artificial Heart Valve	Breast discharge
Skin Cancer	Abdominal pain	Mitral Valve Prolapse	Cancer
Allergy/Immunology	Bowel Change	Heart Problems	Artificial Joints
Seasonal Allergies	Diarrhea	Pacemaker	Kidney Problems
HIV/ Aids	Constipation	Defibrillator	Claustrophobia
ENT	Bloody Stool	Hematologic	Metal implants
Hearing changes	Gallbladder	Anemia	Asthma
Tinnitus	Colon Polyps	Bruising	MRSA infection
Nose Bleeds	Diverticulitis	Bleeding	VRE infection
	Hepatitis	Blood Clots	

Personal History

List all past and current medical problems, and any surgeries with dates

Are you currently taking Coumadin, Aspirin, Plavix or Anti-inflammatory medications? _____

Current Medications including the dosage and frequency:

Have you had any allergy or sensitivity to any medicine: (please describe) _____

Latex allergy? _____ Contrast Dye allergy? _____ Anesthetic reaction? _____

Allergy to Other Substances _____

What Pharmacy do you use _____

Who is your Primary Care Physician? _____

Family Medical History:

Family History	Living	Health	Age at Death	Cause of Death
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

Check Illnesses that have occurred in blood relatives:

Diabetes ___ Bleeding Disorder ___ Mental Illness ___ Stroke ___ Colon Cancer ___
Heart Disease ___ High Blood Pressure ___ Epilepsy/Seizures ___ Colon Polyps ___
Cancer ___ Kidney Disease ___ Asthma ___ Allergies ___

Have you ever received a blood transfusion? _____ Date _____

Social History:

History of Tobacco Use:

Do you use tobacco? _____ What type? _____ How much? _____ How many years? _____
When did you quit? _____

History of Alcohol Use:

Do you use alcohol? _____ What type? _____ How much? _____ How many years? _____
When did you quit? _____

History of Illicit Drug Use:

Have you ever used IV or "street" drugs? _____ What type and amount? _____
When did you quit? _____

Your weight _____ any recent changes in weight _____

Females Only: Menstrual History

Age of onset _____ # of days between periods _____ Duration of flow _____

Date of last period _____ If not menstruating, age when stopped _____