# patient information

DuPage Medical Group
SURGERY

PATIENT NAME

DATE OF BIRTH | AGE

HOME PHONE

WORK PHONE | CELL PHONE

PRIMARY CARE PHYSICIAN

Chief complaint

## past medical history/review of systems

- ☐ Yes ☐ No Heart disease
- ☐ Yes ☐ No Lung disease
- ☐ Yes ☐ No Hypertension
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No History of pulmonary embolism
- ☐ Yes ☐ No History of deep vein thrombosis
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Cancer *please specify*
- ☐ Yes ☐ No Abnormal bleeding
- ☐ Yes ☐ No Sleep disorder
- ☐ Yes ☐ No Elevated cholesterol
- ☐ Yes ☐ No Seizure disorder
- ☐ Yes ☐ No Arthritis, restless leg syndrome
- ☐ Yes ☐ No Headache/sore throat or neck
- ☐ Yes ☐ No Depression/anxiety
- ☐ Yes ☐ No Other past or chronic medical conditions

## drug allergies & reactions

☐ Yes ☐ No Allergy and/or reaction to any type of drug

| *drug* | *rash* | *difficulty breathing* | *other* |
|---|---|---|---|
| | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ |

☐ Yes ☐ No Allergy to latex

Height Weight

## previous surgery

## prescriptions, over-the-counter medications & vitamins/supplements

## social history

- ☐ Yes ☐ No *Smoking* how much how long
- ☐ Yes ☐ No *Alcohol* how much how long
- ☐ Yes ☐ No *Recreational drugs*

Occupation

*continued on back*

**family history** (such as cancer, heart diseases, diabetes...) ______

Signature of patient or guardian completing questionnaire

______ (self/relation ______ )

**sketch**

**for clinical use only**

Patient was sent to us for ______ by Dr. ______

B/P ______ Pulse ______

History of present illness ______

**physical examination**

| | | |
|---|---|---|
| Constitutional | ☐ NL | ☐ ABNL |
| HEENT | ☐ NL | ☐ ABNL |
| Heart | ☐ NL | ☐ ABNL |
| Lungs | ☐ NL | ☐ ABNL |
| Breast | ☐ NL | ☐ ABNL |
| Abdomen | ☐ NL | ☐ ABNL |
| Gertourin | ☐ NL | ☐ ABNL |
| Rectal | ☐ NL | ☐ ABNL |
| Extremities | ☐ NL | ☐ ABNL |
| Skin | ☐ NL | ☐ ABNL |
| Musculoskel | ☐ NL | ☐ ABNL |
| Lymph | ☐ NL | ☐ ABNL |
| Neuro/physc | ☐ NL | ☐ ABNL |
| Other PE | ☐ NL | ☐ ABNL |

☐ Booklet given and questions reviewed

☐ Risk, benefits and alternatives discussed/all questions answered

**facility** ☐ ASC ☐ CDH ☐ CFS ☐ EDW ☐ GS ☐ Other

Surgeon's signature ______

Copy sent to referring physician ______

Initials of staff member sending copies ______

**anesthesia** ☐ GEN ☐ MAC ☐ LOC

Assist ______

Needs to see/cleared by PCP ______

☐ Yes ☐ No Bowel prep

☐ Ancef 1 or 2 grams IVPB
☐ Cipro 400 mg IVPB
☐ Mexofoxin 1 or 2 grams IVPB
☐ Lovenox 30 mg SQ
☐ Clindamycin 600 mg IV
☐ Clindamycin 900 mg IV

☐ Knee high SCDS
☐ Knee high TEDS

**impressions & recommendations** **associated problems**