LINCOLN SURGICAL ASSOCIATES, LTD

1414 Cross Street, Suite 330
Shiloh, IL 62269
618.277.7400 **Phone**
618.277.7422 **Fax**

Health History Form

Patient Name: _____ Date: ___/___/___
Month Day Year

DOB: ___/___/___ Age: ___
Month Day Year

Last Menstrual Period: ___/___/___
Month Day Year

Referring Physician: _____ Primary Care Provider: _____

Main reason for today's visit:
(200 characters maximum)

REVIEW OF SYMPTOMS: Have you had or still have any of the following? *(Check all that apply.)*

Constitutional
- ❑ Recent fevers/sweats
- ❑ Unexplained weight loss/gain
- ❑ Unexplained fatigue/weakness
- ❑ History of cancers
- ❑ None apply

Eyes
- ❑ Change in vision
- ❑ Glaucoma
- ❑ Cataract
- ❑ Blurry/double vision
- ❑ Implants
- ❑ None apply

Ears/Nose/Throat/Mouth
- ❑ Difficulty hearing
- ❑ Hay fever/allergies/congestion
- ❑ Trouble swallowing
- ❑ Voice changes
- ❑ None apply

Breast
- ❑ Breast lumps
- ❑ Axillary node lumps
- ❑ Nipple discharge
- ❑ Skin dimpling
- ❑ None apply

Liver Disease
- ❑ Jaundice
- ❑ Hepatitis

Liver Disease (cont.)
- ❑ Cirrhosis
- ❑ None apply

Respiratory
- ❑ Cough/wheeze
- ❑ Coughing up blood
- ❑ Emphysema
- ❑ Asthma
- ❑ Bronchitis
- ❑ Sleep apnea
  - ❑ CPAP/BiPAP
- ❑ None apply

Cardiovascular
- ❑ Chest pains/discomfort
- ❑ Short of breath with exertion
- ❑ Palpitation
- ❑ Angina
- ❑ High blood pressure
- ❑ Aneurysm
- ❑ Mitral valve prolapse
- ❑ Defibrillator/Pacemaker
- ❑ None apply

Musculoskeletal
- ❑ Muscle/joint pain
- ❑ Recent back pain
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ None apply

Gastrointestinal
- ❑ Heartburn/reflux
- ❑ Blood in stool
- ❑ Nausea/vomiting
- ❑ Pain in abdomen
- ❑ Clay colored stool
- ❑ Dark urine
- ❑ Diarrhea
- ❑ Constipation
- ❑ None apply

Genitourinary
- ❑ Painful/bloody urination
- ❑ Nighttime urination
- ❑ Discharge: penis or vagina
- ❑ Unusual vaginal bleeding
- ❑ Concern with sex functions
- ❑ Dialysis
- ❑ None apply

Endocrine
- ❑ Cold/heat intolerance
- ❑ Increase thirst/appetite
- ❑ Thyroid disease
- ❑ Parathyroid
- ❑ Diabetes
- ❑ Pancreas
- ❑ Adrenal
- ❑ None apply

Psychiatric
- ❑ Anxiety/stress
- ❑ Sleep problems
- ❑ Depression
- ❑ None apply

Neurological
- ❑ Headaches
- ❑ Memory loss
- ❑ Fainting
- ❑ Seizures
- ❑ Weakness
- ❑ None apply

Blood/Lymphatic
- ❑ Unexplained lumps
- ❑ Easy bruising/bleeding
- ❑ Blood clot
- ❑ Autoimmune
- ❑ HIV
- ❑ None apply

Skin
- ❑ Rash
- ❑ New or change in mole
- ❑ Jaundice
- ❑ Cancer
- ❑ None apply

For additional symptoms, please write on last page.

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CURRENT MEDICAL PROBLEMS AND DEVICES: List ALL current medical problems *(CHF, high cholesterol, etc.) and implantable devices or foreign bodies (e.g., shrapnel, etc.)*

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

OPERATIONS: List ALL operations and dates

Operation / Date	Operation / Date
1)	5)
2)	6)
3)	7)
4)	8)

MEDICATIONS: List ALL current medications *(prescription, aspirin, vitamins, herbal, and over the counter)* and history of immunotherapy or hormone replacements.

Name of medicine	Dose/Route	Frequency	Name of medicine	Dose/Route	Frequency
1)			10)		
2)			11)		
3)			12)		
4)			13)		
5)			14)		
6)			15)		
7)			16)		
8)			17)		
9)			18)		

ALLERGIES: List ALL allergies with reactions including medications, food, environmental, or chemical (latex, tape, contrast dye).

Allergy / Reaction	Allergy / Reaction
1)	4)
2)	5)
3)	6)

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Health History Form

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

FAMILY HISTORY: Has anyone in your family had the following? List relationship *(ex. parent, sibling, etc.)*

- ❑ Heart disease/heart attack _____
- ❑ High blood pressure _____
- ❑ Diabetes _____
- ❑ Cancer _____
- ❑ Stroke/vascular disease _____
- ❑ Other _____

SOCIAL HISTORY:

Tobacco Use

❑ Cigarettes ❑ Never Quit Date: _____ ❑ Current Smoker Packs/Day: _____ # of Years: _____

Alcohol Use

Do you drink alcohol? ❑ Yes ❑ No # of Drinks/Week: _____

Drug Use

Do you use or have you used any recreational drugs? ❑ Yes ❑ No

if Yes, list drug(s) and last date used: _____

Have you ever used needles to inject drugs? ❑ Yes ❑ No

SOCIOECONOMICS:

Occupation: _____ Employer: _____

Years of Education/Highest Degree: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Spouse's/Partner's Name: _____

# of Children: _____ Ages: _____

Who lives at home with you?: _____

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Health History Form

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

ADDITIONAL NOTES: Write any additional information or changes below and date.

Name of medicine	Dose/Route	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		

Operation / Date
1)
2)
3)
4)
5)
6)
7)
8)
9)

Date	Change to be Noted

ADDITIONAL NOTES: