Sparrow

Sparrow Medical Group
General Surgery - Lansing
PATIENT HISTORY FORM

Please complete this form and bring it with you to your appointment

Appointment Date & Time: _____ **Referring Physician:** _____

Name: _____ **Home Phone:** _____ **Cell Phone:** _____

Birthdate: _____ **Email Address:** _____

Preferred Method of Contact: Home Phone ☐ Cell Phone ☐ Email ☐

PLEASE LIST OTHER PHYSICIANS THAT YOU SEE:

Name of Physician	Type of Physician	Reason for Seeing

CHIEF COMPLAINT / REASON FOR VISIT

Why are you here? _____

PAST MEDICAL & SURGICAL HISTORY

Have you had or do you currently have any of the following medical conditions? Please circle "YES" or "NO."

High Blood Pressure	YES	NO	Acid Reflux (GERD*)	YES	NO	Blood Clot in Arm / Leg (DVT*)	YES	NO
Heart Disease	YES	NO	Stomach Ulcers	YES	NO	Blood Clot in Lung (PE*)	YES	NO
Heart Attack	YES	NO	Crohn's Disease	YES	NO	Stroke / TIA*	YES	NO
Heart Failure	YES	NO	Ulcerative Colitis	YES	NO	Dementia	YES	NO
Heart Arrhythmia	YES	NO	IBS*	YES	NO	Nerve / Muscle Disease	YES	NO
Peripheral Arterial Disease	YES	NO	Colon Polyps	YES	NO	Seizure Disorder	YES	NO
Asthma	YES	NO	Hemorrhoids	YES	NO	Arthritis	YES	NO
Emphysema (COPD*)	YES	NO	Gallstones	YES	NO	Osteopenia / Osteoporosis	YES	NO
Obstructive Sleep Apnea	YES	NO	Liver Disease (Cirrhosis)	YES	NO	Cellulitis / Abscess	YES	NO
Obesity	YES	NO	Hepatitis A ☐ B ☐ C ☐	YES	NO	MRSA* / VRE* / C. diff*	YES	NO
High Cholesterol	YES	NO	Bowel Obstruction	YES	NO	HIV / AIDS	YES	NO
Diabetes Type 1 ☐ 2 ☐	YES	NO	Groin / Abdominal Hernia	YES	NO	Cancer:	YES	NO
Thyroid Disease	YES	NO	Anemia	YES	NO	Anxiety	YES	NO
Kidney Disease	YES	NO	Bleeding Disorder	YES	NO	Depression	YES	NO

***COPD** = Chronic Obstructive Pulmonary Disease, **GERD** = Gastroesophageal Reflux Disease, **IBS** = Irritable Bowel Syndrome, **DVT** = Deep Vein Thrombosis, **PE** = Pulmonary Embolism, **TIA** = Transient Ischemic Attack, **MRSA** = Methicillin-Resistant *Staphylococcus aureus*, **VRE** = Vancomycin-Resistant *Enterococcus*, **C. diff** = *Clostridium difficile*

Please list any additional medical conditions, major illnesses, traumatic injuries, procedures, surgeries, and hospitalizations below:

_____

_____

_____

_____

_____

ALLERGIES & SENSITIVITIES

Are you allergic or sensitive to latex? YES ☐ NO ☐

Are you allergic or sensitive to any to any medications? YES ☐ NO ☐

Are you allergic or sensitive to any foods, animals, insects, chemicals, or environmental agents? YES ☐ NO ☐

Please list the name of each medication and/or allergen with the corresponding reaction(s) below:

_____

_____

MEDICATIONS

Please list your medications below or bring a separate list indicating each medication by name, the dose you take, and how often you take it.

PHARMACY: _____

NAME STREET ADDRESS CITY PHONE

Medication	Dose	Frequency Taken

FAMILY MEDICAL HISTORY

Family history unknown ☐ Adopted ☐

Family Member	Living	Deceased	Medical Conditions
Mother	☐	☐ age:	
Father	☐	☐ age:	
Sibling 1: Brother ☐ Sister ☐	☐	☐ age:	
Sibling 2: Brother ☐ Sister ☐	☐	☐ age:	
Sibling 3: Brother ☐ Sister ☐	☐	☐ age:	
Sibling 4: Brother ☐ Sister ☐	☐	☐ age:	
Sibling 5: Brother ☐ Sister ☐	☐	☐ age:	
Sibling 6: Brother ☐ Sister ☐	☐	☐ age:	
Maternal Grandmother	☐	☐ age:	
Maternal Grandfather	☐	☐ age:	
Paternal Grandmother	☐	☐ age:	
Paternal Grandfather	☐	☐ age:	
*Other:	☐	☐ age:	
*Other:	☐	☐ age:	
*Other:	☐	☐ age:	
*Other:	☐	☐ age:	

*Others may include additional siblings, children, aunts, uncles, and cousins, etc. Please designate aunts, uncles, and cousins as maternal or paternal.

SOCIAL HISTORY & LIFESTYLE

Do you drink alcohol? YES ☐ NO ☐ PAST USE ☐

If yes or past use, what type and how much?

☐ Cans of Beer: _____ / week ☐ Glasses of Wine: _____ / week

☐ Shots of Liquor: _____ / week ☐ Mixed Drinks: _____ / week

Do you smoke or use tobacco products? YES ☐ NO ☐ PAST USE ☐

If yes or past use, what type?

☐Cigarettes

☐ Cigars

☐ Pipe

☐ E-Cigarettes / Vaping

☐ Chewing Tobacco / Snuff

If yes or past use, for how long have you used or did you use? _____

If you quit smoking or using tobacco products, when did you quit? _____

How much tobacco do you or did you use on a daily basis (e.g., packs per day, cans of chew)? _____

Do you use any street drugs or prescription medications recreationally? YES ☐ NO ☐ PAST USE ☐

If yes or past use, what type?

☐ Opiates

☐ Benzodiazepines

☐ Marijuana / Medical Marijuana

☐ Cocaine / Crack

☐ Heroin

☐ Methamphetamines

☐ Other(s): _____

If yes or past use, how often do you or did you use the aforementioned drug(s) per week? _____

What is your marital status? Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

How many children do you have? _____

What is the highest grade/level of formal education that you have completed? _____

What is your current occupational status? Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐

Who is your current or previous employer? _____

What is your current or previous occupation? _____

Does your job require heavy physical exertion while working? YES ☐ NO ☐

If yes, what types of physical activity are required of you? _____

REVIEW OF SYSTEMS

Constitutional
- ☐ Activity Change ↑ ↓
- ☐ Appetite Change ↑ ↓
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change ↑ ↓ ____ - lbs.

Head, Ears, Nose, Throat
- ☐ Congestion
- ☐ Dental Problem
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Runny Nose
- ☐ Sinus Pain
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Ringing in the Ears
- ☐ Trouble Swallowing
- ☐ Voice Changes

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Sensitive to Light
- ☐ Visual Disturbance

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

Gastrointestinal
- ☐ Abdominal Distention
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Constant Thirst
- ☐ Constant Hunger
- ☐ Large Volume Urine Production

Genitourinary
- ☐ Difficulty Urinating
- ☐ Painful Urination
- ☐ Involuntary Urination
- ☐ Flank Pain
- ☐ Frequent Urination
- ☐ Genital Sore
- ☐ Blood in Urine
- ☐ Urinary Urgency
- ☐ Decreased Urination

Female Genitourinary
- ☐ Menstrual Problem
- ☐ Pelvic Pain
- ☐ Painful Intercourse
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Male Genitourinary
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain

Musculoskeletal
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Difficulty Walking
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Abnormally Pale
- ☐ Rash
- ☐ Wound

Allergy & Immune System
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurological
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Light-Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Fainting)
- ☐ Tremors
- ☐ Weakness

Hematologic & Lymphatic
- ☐ Swollen Lymph Nodes
- ☐ Bruises / Bleeds Easily

Psychiatric
- ☐ Agitation
- ☐ Behavior Problem
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Feeling Down
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous / Anxious
- ☐ Self-Injury
- ☐ Sleep Disturbance
- ☐ Thoughts about Suicide

To the best of my knowledge, all the information provided regarding my health is complete and correct.
I understand that it is my responsibility to inform Sparrow Medical Group General Surgery if I have any changes in my health or health information.

Signature: _____ Date: _____