

PATIENT MEDICAL HISTORY

SEAN LILLE, M.D.

Date _____

Patient Name _____ Birthdate _____ Age _____

Current Weight _____ Height _____ Sex- circle Male or Female

Reason for today's visit _____

ABOUT YOU: Do you have or have you ever had any of the following? CIRCLE

Asthma	Diabetes	Gastric Reflux
Tuberculosis	HIV	Colon Cancer
Lung Disease	High Blood Pressure	Colitis/IBS
Blood Transfusion	Liver Disease	Chemical Dependency
Heart Attack	Hepatitis	Heart Failure
Urinary Incontinency	Ulcer Disease	Breast Cancer
Heart Disease	Tendency to Bleed	Breast lesions/mass
Thyroid Problems	Cancer-Specify	Nephritis
Pneumonia	Rheumatic Fever	Depression
Phlebitis	Gall Bladder disease	Anemia
Rheumatoid Arthritis	Gout	Epilepsy
Hives	Migraines	Kidney Disorder
Alcoholism	IV Drug Use	AIDS

Have you had any of the following operations? Appendectomy Gall Bladder
Tonsilectomy Hysterectomy Hernia Repair Breast Surgeries (what procedure?)

Please list any other surgeries, accidents or serious injuries _____

FAMILY HISTORY OF (circle and list relationship):

Breast Cancer	Stroke	Diabetes
Heart	High Blood Pressure	Epilepsy
Medication Allergies	Migranes	Thyroid
Arthritis	Gall Bladder disease	Ulcers
Kidney Disorder	Blood Diseases	Blood Clots

SOCIAL HISTORY

Do you smoke tobacco? Y N Do you smoke or ingest Cannabis? Y N
Have you ever Smoked? Y N

How much alcohol do you drink per day? _____ or per week? _____

Please circle and list current prescription and over the counter medications you take including **Aspirin Ibuprofen Advil Aleve Fish Oil Vitamin C Vitamin E**

Do you take any weight loss medications? Y N List-_____

Do you take any mood altering medications? Y N List-_____

PRESCRIPTION MEDICATIONS: Please include Birth Control and Hormone Replacements

Medication	Dosage and Frequency	Reason

ALLERGIES: (Please list all allergies here)

VACCINATIONS:

When was your last tetanus booster? (usually every 10 years) _____

Last flu shot? (annually) _____ Have you had a pneumonia vaccine? Y N

Have you had a Hepatitis B vaccine? Y N Have you had a shingles vaccine? Y N

REVIEW OF SYSTEMS: Please circle any symptoms that you currently experience

GENERAL: Fever. Chills. Fatigue. Sweats (inc night sweats) Weight Change (loss/gain ____pounds)

EYES: Change in vision. Glasses. Contact Lenses. Eye pain. Excessive tearing. Cataracts. Glaucoma. Lasik Surgery. Blurred Vision. Laser Surgery. Double Vision. Macular Degeneration. Cataract Surgery. Last eye exam date _____.

EARS/NOSE/MOUTH/THROAT: Frequent colds. Nasal congestion. Hay fever. Nose bleeds. Sinus trouble. Problems with teeth. Bleeding gums. Dentures. Bridgework. Hoarseness. Swollen neck glands. Goiter. Ear Ringing. Ear Pain. Sneezing. Hearing Change. Hearing Aid. Sinus Surgery. Sore throat.

CARDIOVASCULAR: Chest pain. Heart pounding/ fluttering. Shortness of breath with exertion. Ankle swelling. Heart Attack. Angioplasty/Stent. Heart Bypass Surgery. High Blood Pressure.

High Cholesterol. Awakening at night with shortness of breath. Excessive sweating with exertion. Abnormal EKG.

BLOOD: Sickle Cell. Hyper coagulation syndrome. Genetic Blood Syndromes. Previous history of Vein Clots. Anti-clotting medications.

RESPIRATORY: Cough more than 2 weeks. Wheezing. Shortness of breath. Tobacco user. Snoring. Former smoker. Asthma. Coughing up blood. Daytime sleepiness. Excessive phlegm. Last Chest X Ray date _____

GASTROINTESTINAL: Nausea. Vomiting. Indigestion (heartburn). Difficult or painful swallowing. Abdominal pain. Constipation. Blood in stool. Hemorrhoids. Diarrhea. Gallbladder problem. Bloating. Change in bowel habits. History of colon polyps. Poor appetite. Excessive gas. Hiatal Hernia. Diverticulitis. Irritable Bowel. Stomach Ulcers. Have you had colon cancer screening (colonoscopy or flexible sigmoidoscopy)? Y N When? _____

GENITO-URINARY: Poor urine control. Urinary Incontinence. Frequent Urination. Urgent Urination. Burning with urination. Blood in urine. Slow urine stream. Kidney Stones. Difficulty starting urine stream. Arising at night to urinate. Incomplete emptying of bladder. Sexual dysfunction.

WOMEN ONLY: Periods (Regular, Irregular, Painful, Don't have periods) Hot flashes. Menopausal. Vaginal Discharge. Breast Lump. Nipple discharge. Genital ulcers. Pregnancies _____ Births _____ Date of last mammogram _____ Date of last Pap Smear _____ Performed by _____ Do you wish to discuss AIDS or venereal disease? Y N

MEN ONLY: Hernias. Lump in testicle. Pain in testicles. Sores or skin lesions of genital area. Prostate trouble. Sexually transmitted disease. Vasectomy. Do you wish to discuss AIDS or venereal disease? Y N

BONES/ JOINTS: Muscle pain or aching. Leg pain. Stiffness. Painful joints. Joint swelling. Back pain Neck pain. Arthritis. Disc disease of spine. Osteoarthritis. Osteoporosis. Serious joint/bone injuries. Muscle weakness. Orthopedic surgery.

SKIN: Rash. Itching. New skin lesion. Lumps. Sores. Change in moles. Dry skin. Skin Cancer. Leg Ulcers.

NEUROLOGICAL: Headache. Dizziness. Seizures. Numbness. Paralysis. Stroke. Memory Loss. Tremors (shakiness). Weakness. Difficulty Walking. Falls. Sleep difficulties. Vertigo. Confusion. Passed out. Unsteady gait. Tingling of skin.

PSYCHIATRIC: Nervousness/ anxiety. Depressed. Crying spells. Lack of enjoyment of things. Agitation. Panic attacks. Increased stress from family/ work/ finances. Hallucinations. Disoriented. Psychological/ psychiatric counselling. Sleep difficulties.

ENDOCRINE/ HEMATOLOGIC/ ALLERGY: Anemia. Easy bruising/ bleeding. Thyroid trouble. Diabetes. Blood transfusion. Enlarged lymph nodes. Allergy skin tests. Allergic skin reactions. Frequent infections.

SURGICAL THROMBOSIS RISK FACTOR ASSESSMENT

CIRCLE ALL THAT APPLY

Each Risk Factor Represents 1 Point: Age 41-60 years, Minor Surgery Planned, Varicose Veins, History of prior major surgery (<1 month), History of Inflammatory Bowel Disease, Swollen legs (current), Obesity (BMI> 25), Acute myocardial Infarction, Congestive Heart Failure (<1 month), Sepsis (<1 month), Serious Lung disease incl. pneumonia (<1 month), Abdominal pulmonary function (COPD), Medical patient currently at bed rest, Other risk factors _____

Each Risk Factor Represents 2 Points: Age 60-74 years, Arthroscopic Surgery, Major Surgery, Malignancy (present or previous), Laparoscopic Surgery (>45 minutes), Central venous access, Patient confined to bed (>72 hours), Immobilizing plaster cast (<1 month)

Each Risk Factor Represents 3 Points: Age over 75 years, History of DVT/PE, Positive factor V Leiden *Family history of thrombosis**, Positive Prothrombin 20210A, Elevated serum homocysteine, Positive lupus anticoagulant, Elevated anticardiolipin, antibodies, Heparin-induced thrombocytopenia/ HIT Other congenital or acquired thrombophilia- if yes: Type _____
**most frequently missed risk factor*

Each Risk Factor Represents 5 Points: Elective major lower extremity arthroplasty, Stroke (<1 month), Hip, pelvis or leg fracture (<1 month), Multiple trauma (<1 month), Acute spinal cord injury (paralysis)

For Women Only (Each Represents 1 point): Oral Contraceptives or Hormone Replacement Therapy, Pregnancy or postpartum (<1 month), History of recurrent spontaneous abortion (>3 months), Unexplained stillborn infant, premature birth with toxemia or growth restricted infant

TOTAL RISK FACTOR SCORE _____