

MSU DEPARTMENT OF SURGERY PATIENT PROFILE

LEGAL NAME: _____ **NAME YOU PREFER:** _____
BIRTHDATE: _____ **AGE:** _____ **HT:** _____ **WT:** _____ **OCCUPATION:** _____
PRIMARY DOCTOR: _____ **REFERRING DOCTOR:** _____

REASON FOR VISIT TODAY: _____

PLEASE LIST ANY ALLERGIES OR SENSITIVITIES TO MEDICATIONS/FOOD/LATEX/OTHER:

PLEASE LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS (INCLUDE DATES):

PLEASE CIRCLE ANY OF THE FOLLOWING DIAGNOSES THAT APPLY:

- | | | | |
|------------------------------------|------------------------|---------------------|-----------------------------|
| Anemia | CVA/Stroke | Emphysema | Myocardial Infarction |
| Anesthesia Complications | Coronary Heart Disease | GERD | Mitral Valve Prolapse |
| Antibiotic use prior to procedures | Chronic Renal Failure | Hepatitis A B C | Osteo/Rheumatoid arthritis |
| Asthma | Cirrhosis | High Cholesterol | Osteoporosis |
| Atrial Fibrillation | Colon Cancer | High Blood Pressure | Pancreatitis |
| Blood Transfusions | Crohn’s Disease | Hypothyroidism | Peripheral Vascular Disease |
| Breast Cancer | Deep Vein Thrombosis | Hyperthyroidism | Pulmonary Embolism |
| Breast Disease | Depression | IBS | Seizure Disorder |
| COPD | Diabetes-Type I | Kidney Disease | Tuberculosis |
| Cancer: _____ | Diabetes-Type II | Kidney Stone | Valvular Heart Disease |
| | Diverticulitis | Morbid Obesity | Varicose Veins/Phlebitis |
| | | MRSA | VRE |

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING BIRTH CONTROL AND “OVER THE COUNTER” MEDS OF ASPIRIN, TYLENOL, VITAMINS, ETC. (INCLUDE DOSAGE)

FAMILY HISTORY (Blood relatives only)

CANCER: Breast, Cervical, Colon, Liver, Lung, Ovarian, Pancreatic, Prostate, Skin, Melanoma
 Coronary Heart Disease Colon Polyps Thyroid Disease

PLEASE CIRCLE ANY CONDITIONS THAT APPLY TODAY OR ON AN ONGOING BASIS:

GENERAL: No concerns

Fever Loss of appetite Weight Loss
Fatigue Anemia

HEAD/EYE/EAR/NOSE/THROAT: No concerns

Decreased hearing Sore throat
Neck swelling Goiter Thyroid problems
Mandibular/jaw fracture Nasal fracture Dentures
Seizures Frequent headaches Glaucoma
Cataracts Blurred vision Eye injury

STOMACH/DIGESTION: No concerns

Abdominal pain Nausea Vomiting
Diarrhea Constipation Change in bowel habits
Black tarry stools Blood in stools Hepatitis
Gas/Bloating Indigestion/Heartburn
Difficulty swallowing Painful swallowing
Recent weight loss

BREAST: No concerns

Left breast lump Right breast lump
Nipple discharge Bloody nipple discharge
Breast pain Abnormal mammogram
Breast enlargement Nipple inversion

HEART/CIRCULATION: No concerns

Chest pain Irregular heart beat
Fainting/Blackout spells
Swelling of arms or legs
History of heart attack Stents Heart surgery

PULMONARY/LUNGS: No concerns

Cough Shortness of breath Blood in sputum
Wheezing Pain with breathing Use of oxygen
COPD Asthma

URINARY: No concerns

Incontinence Painful urination Blood in urine
Urinary frequency Urinary hesitancy Nocturia

FEMALE ONLY:

Vaginal discharge Abnormal vaginal bleeding
Pelvic pain Pregnancy Menopause HRT
of pregnancies _____ # of live births _____
Last menstrual period: _____

MALE ONLY: No concerns

Abnormal discharge Erectile dysfunction

WOUND: No concerns

Redness Discharge Pain Opening of wound
Purulent discharge Bleeding from wound

SKIN: No concerns

Suspicious lesions New skin lesions
Changing mole(s) Rash
Itching History of skin cancer

NEUROLOGICAL: No concerns

Paralysis Paresthesias Seizures Dizziness
Frequent headaches History of Alzheimer's
History of stroke Head Injury

PSYCHOLOGICAL: No concerns

Depression Anxiety Memory loss
Thoughts of suicide Hallucinations
Claustrophobia

ENDOCRINE: No concerns

Heat intolerance Cold intolerance
Unusual weight change
Exposure to radiation Hair loss

HEMATOLOGY: No concerns

Abnormal bruising or bleeding
Enlarged lymph nodes Anticoagulation
Transfusion Anemia

MUSCULOSKELETAL: No concerns

Back pain Sciatica Arthritis

OTHER: No concerns

Stoma: Redness Pain Discharge
Vascular access: Redness Pain Discharge

SOCIAL HISTORY

Tobacco use? Current Quit Never
Year Started _____ Year Quit _____
How much per day? _____
Second Hand Smoke? Yes No
Alcohol use? Yes No
Use of cocaine, marijuana, heroin, steroids? Yes No
History of treatment for substance abuse? Yes No
Hit, Slapped, or Kicked within past year? Yes No
Sexually Abused within past year? Yes No
Religious beliefs affecting care? Yes No