Central Ohio General Surgeons
Formerly Lancaster Surgical Associates
General and Laparoendoscopic Surgery

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COGS PATIENT MEDICAL HISTORY FORM

Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____ **Cardiologist:** _____

Primary Care Physician: _____ **Pain Management:** _____

OB/GYN Physician: _____ **Other:** _____

REASON FOR VISIT *(circle/fill in blank):*

What are your symptoms? _____

_____

Do you have pain? *Y / N*

Describe the pain:

achy / burning/ dull / sharp / stabbing

Other: _____

How severe is the pain?

Mild / moderate / severe / incapacitating

Location of the pain? _____

Does the pain radiate? *Y / N*

If yes, what location?

_____

How long have you had this problem?

Days / weeks / months / years

What makes the problem better? _____

_____

Have you taken any medication to help the problem?

Tylenol / Advil / narcotic pain pill (_____)

What makes the problem worse? _____

_____

Do you have any other symptoms? *(circle)*

Fever / chills / night sweats / decreased appetite/ nausea / vomiting/ weight loss / weight gain / constipation / diarrhea / blood in the stool / painful BMs / black stools abdominal bloating, cramps or pain

ANY HISTORY OF INFECTIONS?

Do you or does anyone in your family/household

Have or a history of: **MRSA?** ☐ yes ☐ no

VRE? ☐ Yes ☐ No **STMAL?** ☐ Yes ☐ No

ESBAL? ☐ Yes ☐ No **C.DIFF?** ☐ Yes ☐ No

EDUCATION HISTORY: (circle)

Highest level of education:

Grade level: 1 2 3 4 5 6 7 8 9 10 11 12

GED

College: 1 2 3 4

Graduate School

Professional School

WORK HISTORY:

Job title_____

Retired_____

What type of work did you do?

_____

Un-employed _____

Disabled_____

Other _____

Tobacco use? ☐Y ☐N ☐ quit _____ year

Current smoker:

how many packs per day? _____ ppd (packs per day)?

Former smoker:

how many years did you smoke? _____

Smokeless tobacco? Y / N_____

Do you use alcohol? ☐ Y ☐ N

How many? _____ Daily _____ weekly beer / wine / liquor

Substance abuse? *Never / current / former*

Narcotic abuse? *Never / current / former*

Caffeine use: *coffee / tea / energy drinks*

Dietary supplements: _____

Vitamins: _____

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FEMALE PAST HISTORY: (circle)

Are you currently pregnant? *Y / N*

# of total pregnancies: ____ **# of children:** ____

Your age at 1st pregnancy: _____

Did you breast feed? Y / N **if yes, how many months?** ____

Oral contraceptive use? Y / N **if yes, how many years?** _____

Hormone replacement? Y / N **if yes, how many years?** _____

Did you have a Hysterectomy *Y / N what year?* _____

Age at first menstrual period: _____

Date of last menstrual period: _____

Where do you get your mammograms?

_____

Date of last mammogram: _____

IMPLANTED DEVICES: (circle)

Port
Pace-maker / AICD
Spinal Cord Stimulator
Pain Pump
Insulin Pump

PROSTETIC JOINTS: *Y / N*

Knee: right / left / both *(circle)*
Hip: right / left / both *(circle)*
Other: _____

DO YOU TAKE BLOOD THINNERS? Y / N

Name of drug: (circle) reason drug prescribed:

Coumadin_____
Plavix_____
Aggrenox_____
Pradaxa_____
Other_____

PROSTHETIC HEART VALVE? *Y / N* Aortic / mitral *(circle)*

Metal / porcine / bovine *(circle)*

Do you take Coumadin? *Y / N*

Do you take antibiotics before procedures? *Y / N*

*If yes, what antibiotic?*_____

ANY PAST SURGERY CONCERNS:

Have you had any problems with anesthesia?

Airway problem / breathing / heart / nausea / vomiting

Is there a family history of either? *(circle)*

Malignant hyperthermia or
Pseudocholinesterase deficiency

MEDICAL PROBLEMS: ***(please check all problems you are being treated for)***

- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer
  Type: _____
- ☐ Chest Pain
- ☐ Cirrhosis
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Eye Trouble
- ☐ Gallstones
- ☐ GERD
- ☐ Headache
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Leg Pain/Swelling
- ☐ Mitral Valve Prolapse (MVP)
- ☐ Rectal Disease
- ☐ Seizures
- ☐ Sexually Trans. Disease (STD)
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stomach/Ulcer
- ☐ Stroke/TIA
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ Low Blood Pressure

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PAST SURGICAL HISTORY:

Year Of Last Colonoscopy	Facility/Location	Surgeon	Year

Year Of Last Mammogram	Facility/Location	Normal Biopsy	Finding (If Known)

Prior Surgeries	Facility/Location	Surgeon	Year
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES: **Are you allergic to any of the following?** *Iodine / fish / eggs / IVP dye*

Medication Allergy	Allergic Reaction*	Severity
1.		
2.		

**(options: unsure, mild reactions: rash, hive, itching, nausea, vomiting; severe reactions: fever, throat swelling, anaphylaxis)*

* IF YOU HAVE A CURRENT LIST OF MEDICATION, PLEASE BRING TO APPOINTMENT. WE WILL MAKE A COPY FOR CHART.

Having a copy ready for our office ensures you will not have to write down your list of medication below. Thank you.

CURRENT MEDICATIONS:	#mg:	Directions:	Reason for taking Medication:	Prescriber: