OhioHealth Surgical Specialists

Name: _____Date: _____

Reason for visit: _____

How long have you had symptoms related to the reason for your visit? _____

Please circle yes or no if you are experiencing or have experienced any of the following symptoms. Please put a check mark under current or past if you are experiencing symptom currently or have had in the past:

General Health			**Current**	**Past**
Weight Loss	Yes	No	____	____
Weight gain	Yes	No	____	____
Loss of appetite	Yes	No	____	____
Tired/fatigue	Yes	No	____	____
Physically weak	Yes	No	____	____
Fevers or chills	Yes	No	____	____
Night sweats	Yes	No	____	____

Eyes				
Past eye disorders	Yes	No	____	____
Vision changes	Yes	No	____	____
Eye discharge	Yes	No	____	____
Dry eyes	Yes	No	____	____

Ears				
Hearing loss	Yes	No	____	____
Ear pain	Yes	No	____	____
Ear discharge	Yes	No	____	____

Nose/Throat				
Nasal drip	Yes	No	____	____
Sores in/around mouth	Yes	No	____	____
Sore throat	Yes	No	____	____
Change in voice	Yes	No	____	____
Hoarseness	Yes	No	____	____

Lungs				
Shortness of breath	Yes	No	____	____
Asthma/wheezing	Yes	No	____	____
Do you use oxygen?	Yes	No	____	____
Coughing	Yes	No	____	____
Chest pain	Yes	No	____	____
Coughing up blood	Yes	No	____	____
Snoring or stop breathing	Yes	No	____	____

Cardiovascular				
Have you ever had a heart attack?	Yes	No	___	___
Chest pain or pressure	Yes	No	___	___
Short of breath lying down	Yes	No	___	___
Swelling of legs	Yes	No	___	___

Hematologic			**Current**	**Past**
History of anemia	Yes	No	____	____
history of cancer	Yes	No	____	____
Easy bruising	Yes	No	____	____
Bleed for a long time after a cut?	Yes	No	____	____
History of blood clots	Yes	No	____	____

Gastrointestinal				
History of bowel problems	Yes	No	____	____
History of stomach ulcers	Yes	No	____	____
Trouble swallowing	Yes	No	____	____
Pain with swallowing	Yes	No	____	____
Heartburn	Yes	No	____	____
Abdominal pain	Yes	No	____	____
Swelling of abdomen	Yes	No	____	____
Nausea or throwing up	Yes	No	____	____
Constipation	Yes	No	____	____
Diarrhea	Yes	No	____	____
Black or tarry stools	Yes	No	____	____
Bloody stools	Yes	No	____	____
Hemorrhoids	Yes	No	____	____
History of Hepatitis	Yes	No	____	____
Have you had a colonoscopy?	Yes	No		
if Yes, when was it? _____				

Genitourinary				
History of bladder cancer	Yes	No	____	____
History of kidney stones	Yes	No	____	____
History of trauma to genitals	Yes	No	____	____
History of sexually transmitted Infection?	Yes	No	____	____
Blood in urine	Yes	No	____	____
Burning/discomfort urinating	Yes	No	____	____
Trouble holding your urine	Yes	No	____	____
Urinating at night	Yes	No	____	____
Incomplete emptying	Yes	No	____	____

			Current	Past
Have you ever had a stress test?	Yes	No	___	___
Fainting	Yes	No	___	___
Fast or irregular heartbeat	Yes	No	___	___
Leg pain with walking	Yes	No	___	___
Wounds or ulcers on feet/leg	Yes	No	___	___
Neurological				
Headache	Yes	No	___	___
History of stroke or seizures	Yes	No	___	___
Sudden weakness or numbness	Yes	No	___	___
Temporary blindness in one eye	Yes	No	___	___
Facial drooping	Yes	No	___	___
Slurred speech	Yes	No	___	___
Dizziness	Yes	No	___	___
Balance problems	Yes	No	___	___
Tremors/shaking	Yes	No	___	___
Mental Health				
History of anxiety or depression	Yes	No	___	___
History of schizophrenia	Yes	No	___	___
History of bipolar disorder	Yes	No	___	___
Feeling sad most of the time	Yes	No	___	___
Alcohol abuse	Yes	No	___	___
Tobacco dependence	Yes	No	___	___
Memory problems	Yes	No	___	___
Confusion	Yes	No	___	___
Endocrine				
History of diabetes	Yes	No	___	___
History of thyroid problems	Yes	No	___	___
Excessive thirst or drinking	Yes	No	___	___
Do you often feel hot or cold	Yes	No	___	___

			Current	Past
For Men:				
History of prostrate cancer	Yes	No	____	____
Testicular pain/swelling	Yes	No	____	____
Penile discharge	Yes	No	____	____
For Women: (OB/GYN)				
History of endometriosis	Yes	No	____	____
Vaginal discharge	Yes	No	____	____
Are you still having periods?	Yes	No	____	____
Date of last period: _____				
Heavy bleeding with periods	Yes	No	____	____
Allergy/Immunologic				
History of auto-immune disease	Yes	No	____	____
History of HIV	Yes	No	____	____
Frequent sinus problems	Yes	No	____	____
Catch cold easily	Yes	No	____	____
Skin/Breast				
History of psoriasis	Yes	No	____	____
History of skin cancer	Yes	No	____	____
Hair loss	Yes	No	____	____
Rashes/itching	Yes	No	____	____
New skin growths	Yes	No	____	____
Sores that grow and/or don't heal	Yes	No	____	____
Lesions changing size, shape, or color	Yes	No	____	____
Breast mass, pain or discharge	Yes	No	____	____
Musculoskeletal				
History of arthritis or gout	Yes	No	____	____
History of Lupus	Yes	No	____	____
Sore muscles	Yes	No	____	____
Joint aches	Yes	No	____	____

Significant Family History of Cancer, Colon polyps, Heart/Lung Disease:_____

_____

Allergies: please list all allergic reactions below, especially medications: _____

_____

Medications: please list all medications you are taking (Rx & OTC) and why you need them:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Richard R. Costin, DO **James M. Massullo, MD**