Gailey Patient Health Record

(Please complete with BLACK ink pen.)

Name:	Patient phone number:
Address:	❑ Home ❑ Mobile ❑ Work
City:	Secondary phone number:
State: Zip code:	❑ Home ❑ Mobile ❑ Work
SSN: - - Gender: M / F	May staff leave a voice message at the above numbers? Yes / No
Birthdate: Height:	
Age: Weight:	Email:
Marital Status (circle): S M D W SEP	Job status (circle): FT PT Retired Disabled Unemployed
Were you referred by another physician: Yes / No	Name of referring physician:

Questions 1-5 ARE REQUIRED BY THE STATE OF ILLINOIS, THEY MUST BE ANSWERED PRIOR TO YOUR SURGERY

1. What is your ethnicity? ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unknown/Decline	2. What is your race? (You must select an answer) ❑ White ❑ Asian ❑ Mix race ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ American Indian or Alaska Native ❑ Other race ❑ Unknown/Decline

3. Is your primary place of residence a Nursing Home? Yes / No

Is your primary place of residence an Assisted Living Facility? Yes / No

Are you **temporarily** residing at a Nursing Home, Assisted Living, Intermediate Care, or Rehab Facility? Yes / No

Are you currently in the custody of Law Enforcement (imprisoned or detained)? Yes / No

Are you currently under Hospice Care? Yes / No ❑ At Home ❑ At a Facility

Facility Name (if answered Yes to any of the above): Phone number:

4. Do you require a translator? Yes / No What services do you need?

If yes: Do you have someone who will be able to translate when a phone call is made to you? Yes / No

Will you have someone with you who will be able to translate for any surgery? Yes / No

5. Do you have an advance directive? ❑ No ❑ Living will ❑ Power of Attorney for Healthcare

6. Traveled /contact with traveler outside of the USA within the past 21 days? Yes / No Date(s): Location:

7. Are there any religious or cultural practices that the staff needs to be aware of while here? Yes / No Specify:

8. Do you follow a certain diet at home? Yes / No If yes, explain:

9. Answer if patient is 16 or under:
Any developmental delays? Yes / No If yes, explain:
Childhood immunizations up-to-date? Yes / No If no, explain:

10. Do you use a wheelchair: Yes / No Can you bear weight? Yes / No

Primary care physician:	Pulmonologist:
Office number:	❑ none Office number:
Cardiologist:	Have you had any of the following in the past month? ❑ None
❑ none Office number:	❑ Cold ❑ Flu
Have you ever had a problem with an anesthetic? Yes / No	❑ Sore throat ❑ Fever
If yes, what happened?	❑ Injury ❑ Congested cough
Has a family member had a problem with an anesthetic? Yes / No	❑ Bronchitis ❑ Pneumonia
If yes, what happened?	❑ Hospitalization

Do you use tobacco? Yes / No What? How many years? Quit When? Packs/day:

Do you drink alcohol? Yes / No If yes, amount per day: week: month:

Do you use street drugs? Yes / No If yes, drug name: Last used:

Current Medications list prescription, non-prescription & herbals	Drug name	Dose/frequency	Drug name	Dose/frequency
❑ No medications				
❑ See attached meds				

Turn over page and complete the other side.

OFFICE USE ONLY. BMI:_____

Can you lie flat for 20 minutes? ❑ **Yes** ❑ **No**

Previous surgeries	❑ No surgeries	List type and year _____
Allergies	❑ No allergies	medications, food, environmental, balloons, and/or latex and reaction _____

Check "Yes" if you have a history of any of the following conditions:

	Yes	Condition	Comments
Cardiac		**Heart attack (MI)**	Date(s):
		❑ Mitral valve prolapse ❑ heart murmurs ❑ valve disorder/replacement	
		Fast or Irregular heart beat	❑ afib/aflutter ❑ other
		Cardiac stent	Date(s):
		Congestive heart failure	
		High blood pressure	
		Pacemaker	Date(s):
		Automatic defibrillator (AICD)	Date(s):
		Rheumatic fever	
		Coronary artery disease (CAD)	
		Aortic stenosis	
Neuro		**Stroke (CVA)**	Date(s):
		Cerebral palsy	
		Multiple sclerosis	
		Seizure disorder/epilepsy	
		Meningitis	
		Parkinson's Disease	
GI/GU		Diabetes	❑ Insulin ❑ Pills ❑ Diet
		Ulcers	
		GERD or acid reflux	
		Hiatal hernia	
		❑ Liver disease ❑ Jaundice ❑ Hepatitis	
		Kidney: ❑ disease ❑ stone	Specify:
		Dialysis	
		Incontinence/frequency	
		Bowel problems	Specify:
		Prostate problems	Specify:

	Yes	Condition	Comments
Pulmonary		**Pulmonary fibrosis**	
		Bronchiectasis	
		❑ **COPD** ❑ Emphysema	❑ Hospitalized in the last year
		Pulmonary hypertension	
		Bronchitis/Chronic cough	
		Asthma	
		Shortness of breath	
		On oxygen	❑ Continuous ❑ At night
		CPAP/Sleep apnea	
		Tuberculosis	
Other		Myasthenia gravis	
		Myotonic dystropy	
		Pain:❑ Chest ❑ Back ❑ Other	
		❑ Depression ❑ Anxiety	
		❑ Dementia ❑ Alzheimer's	
		Handicaps: ❑ Mental ❑ Physical	Specify:
		Headache/migraines	
		Motion sickness	
		Arthritis	
		Thyroid	❑ High ❑ Low
		Cancer (Type & treatment)	
		Breast Cancer	❑ Left ❑ Right
		AIDS/HIV	
		Wounds/Blisters	Where:
		Antibiotic resistant infection (MRSA, VRE, Other)	
		Piercings/Tattoos:	Where:
		❑ Prosthesis ❑ Artificial joints ❑ Radioactive implants	Where:
		Are you pregnant?	
		Last Menstrual cycle	Date:

If "No" to all of the above, check here: ❑

Patient or legal patient representative signature: X_____ Date:_____

DO NOT WRITE BELOW. OFFICE USE ONLY.

Health update

New form MUST be completed if above date is more than 12 months old; if date is more than 3 months old, update section below

Surgery Date: _____ Health changes at this time: Yes / No

If yes, list (medication changes, new conditions/procedures, new allergies): _____

Patient or legal patient representative signature: _____ Date:_____