Gailey Patient Health Record

(Please complete with BLACK ink pen.)

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

QUESTIONS 1-5 ARE REQUIRED BY THE STATE OF ILLINOIS

1. What is your race? ❑ White ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ American Indian or Alaska Native ❑ Multi-Racial ❑ Other ❑ Decline

2. What is your ethnicity? ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Decline

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

Is your primary 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 receiving Hospice Care? Yes / No

If yes, check one: ❑ Hospice at Home ❑ Hospice at a Facility

If you answered YES to any of the above, please provide:

Facility Name:

Facility Phone Number:

4. Do you require a translator? Yes / No

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

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

Preferred language to receive medical information?

5. Do you have an advance directive? Yes / No

If yes, what? ❑ Living Will ❑ Power of Attorney for Healthcare

6. In the past month, have you or someone you have been in contact with traveled outside the U.S.A. or to parts of the U.S. known to have infectious outbreaks? Yes / No

If yes, dates: Location:

7. Do you have any religious or cultural practices our staff needs to be aware of while you are here? Yes / No

If yes, specify:

8. Do you follow a certain diet at home? Yes / No

If yes, explain:

9. **ANSWER QUESTION 9 IF THE PATIENT IS 16 OR YOUNGER:**

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

If yes, can you bear weight? Yes / No

11. Have you had any of the following in the past month? ❑ None

❑ Pneumonia ❑ Cold ❑ Cough ❑ Fever ❑ Injury ❑ Bronchitis ❑ Sore Throat ❑ Flu ❑ Hospitalization

12. Do you use: Tobacco? Yes / No Marijuana? Yes / No

If yes, in what form?

If yes, amount per day: week: month:

13. Do you drink alcohol? Yes / No

If yes, amount per day: week: month:

14. Do you use street drugs? Yes / No

If yes, drug name: Last used:

15. **ANESTHESIA QUESTIONS**

Can you lie flat for 20 minutes? Yes / No

If no, explain:

Can you walk up a flight of stairs or walk a block without shortness of breath or chest pain? Yes / No

If no, explain:

Have you ever had a problem with an anesthetic? Yes / No

If yes, explain:

Has a family member had trouble with anesthesia? Yes / No

If yes, explain:

Have you had a difficult intubation? Yes / No

If yes, explain:

Primary Care Physician:	**Cardiologist:**	**Pulmonologist:**
Office number:	Office Number:	Office number:

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: _____

NAME:
DOB:

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

Check "Yes" if you have a history of any of the following conditions. If none of these apply to you, check here: ❑

	Yes	Condition	Comments
Cardiac		Heart attack (MI)	Dates:
		❑ Mitral valve prolapse ❑ heart murmurs ❑ valve disorder/replacement	
		Fast or Irregular heart beat	❑ afib/aflutter ❑ other
		Cardiac stent	Dates:
		Congestive heart failure	
		High blood pressure	
		Pacemaker	Dates:
		Automatic defibrillator (AICD)	Dates:
		Rheumatic fever	
		Coronary artery disease (CAD)	
		Aortic stenosis	
		Chest Pain	❑ New ❑ Chronic ❑ Occurs with Exertion
Neuro		Stroke (CVA)	Dates:
		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		**COVID-19 Virus: When did you test positive?** _____ Vaccinated?: ❑Yes ❑No Brand:_____ Dates:_____ _____	
		Down Syndrome	
		Myasthenia gravis	
		Myotonic dystrophy	
		Pain: ❑ Back Pain ❑ Other	
		❑ Depression ❑ Anxiety	
		❑ Dementia ❑ Alzheimer's	
		Handicaps: ❑ Mental ❑ Physical	Specify:
		Headache/migraines	
		Motion sickness	
		Arthritis	❑ Osteo ❑ Rheumatoid
		Thyroid	❑ High ❑ Low
		Cancer (Type & treatment)	
		Breast Cancer	❑ Left ❑ Right
		AIDS/HIV	
		Wounds/Blisters	Where:
		Antibiotic resistant infection	❑ MRSA ❑ VRE ❑ _____
		Piercings/Tattoos:	Where:
		❑ Prosthesis ❑ Artificial joints ❑ Radioactive implants	Where:
		Are you pregnant?	
		Last Menstrual cycle	Date:

Patient or legal patient representative signature: X_____ Date:_____

Completed by phone with ❑ Patient or ❑ _____ Relationship: _____

Staff Signature: _____ Date/Time: _____

DO NOT WRITE BELOW. OFFICE USE ONLY.

Health update

A new form MUST be completed if above date is more than 12 months old; if date is more than 3 months old, update below:

Surgery Date: _____ Have you had any health changes since this form was completed? Yes / No

If yes, list (new medications/conditions/procedures/allergies):

Patient or legal patient representative signature: _____ Date:_____