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 ❑ Other ❑ 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	Drug name	Dose/frequency	Drug name	Dose/frequency
list prescription, non-prescription & herbals				
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:______________