METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Metro Health – University of Michigan Health

Thoracic Surgery

Patient History Information

In an effort to serve you better, we request that you provide us with the following information. This information allows us to provide the best care and treatment possible. All information is strictly confidential and is released only with our written consent.

Please complete ALL pages and bring to your appointment.

Date:_____

Last Name:_____ First Name:_____ M.I._____

Address:_____

Date of Birth:_____ Phone: ( )_____ Last 4 digits of your SS#:_____

Sex: Male/ Female Race: (Cancer Research Purposes Only):_____

Primary Physician:_____ Referring Physician:_____

Surgeon:_____ Other:_____

Primary Pharmacy:

Name of Pharmacy:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Phone: ( ) _____

Please indicate if you have or have had any of the following:

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis (TB)
- ☐ High Blood Pressure
- ☐ Heart Attack/Heart Disease
- ☐ Irregular Heart Rhythm
- ☐ Rheumatic Fever
- ☐ Blood Clots
- ☐ Anemia or a Blood Disorder
- ☐ Blood Transfusion(s) (if yes) When _____
- ☐ History of Pneumonia (if yes) When _____
- ☐ Stroke
- ☐ Seizures
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Hepatitis/Jaundice
- ☐ Diverticulosis/Colon Problems
- ☐ Ulcers
- ☐ Previous Cancer
- ☐ Diabetes
- ☐ If Diabetic -Recent HGB A1C value_____
- ☐ Arthritis
- ☐ Depression

Have you ever had MRSA/VRE related wound infections? Yes No

Please List your Previous Surgeries, including year and where they were performed:

Year	Operation and Where

History of Anesthesia Reactions: Yes No

If yes, please explain:_____

Family History

Please indicate with a check mark if any *relatives* have had any of the following:

- ☐ Thyroid (goiter)
- ☐ Anemia
- ☐ Easy Bleeding
- ☐ Lupus
- ☐ Stroke
- ☐ Diabetes (sugar)
- ☐ Alcoholism
- ☐ Other
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Emphysema
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Cirrhosis/liver disease
- ☐ Arthritis

(Please include Patents, Grandparents, Aunts, Uncles, Sisters, and Bothers)

- ☐ Cancer What Type:_____ Relationship to you :_____
- ☐ Cancer What Type:_____ Relationship to you :_____
- ☐ Cancer What Type:_____ Relationship to you :_____
- ☐ Cancer What Type:_____ Relationship to you :_____

Social History

Marital Status: *Married Single Widowed Divorced*

_____*No. of Children*

Employment Status: Full-time Part-time Student Self-employed Not employed Retired

Employer Name/ Occupation:_____

Education Level: Grade School Jr. High High School College Post Graduate

Do you or have you ever smoked? Yes No Amount per Day: _____ How many years:_____

Quit Date (if applicable) :_____

Do you or have you ever used chewing tobacco? Yes No Amount Per Day:_____

How many years:_____ Quit Date (if applicable) :_____

Do you drink alcohol? Yes No Type: Beer/Wine amount per week:_____

Liquor amount per week:_____

Do you or have you ever used recreational drugs? Yes No Type Used:_____
Chronic Opioid/Narcotic use? Yes No

Medications

Please list all medications you are taking:

Name of Drug:	Dose:	Times per day:

(Please add any additional medications to the back of this form)

Allergies:	Type of Reaction:

(Please add any additional medications to the back of this form)

Please circle those problems you have experienced within the past 6 months:

General: Weight Loss Fatigue Fever Night Sweats Weakness

Skin: Itching Rash Lumps Change in a mole

Eyes: Visual changes Cataracts Glaucoma Double Vision Blurry vision

Breasts: Lumps Drainage Tenderness Skin Changes

Lungs: Shortness of Breath Cough Coughing up blood Wheezing Difficulty breathing when laying down

Heart: Chest Pain Palpitations Swelling of the feet/legs Fainting episodes Heart murmur

Abdomen: Abdominal pain Nausea Vomiting Jaundice Blood in stool Black Stools Trouble swallowing Abdominal bloating Diarrhea Constipation Hemorrhoids Loss of appetite

Urinary: Painful urination Increased frequency of urination Incontinence Difficulty starting a stream of urine Blood in urine Kidney Stones Urinating frequently at night

Musculoskeletal: Muscle weakness Arthritis Joint stiffness Backache

Neurological: Headaches Seizures Anxiety Depression Numbness or Tingling Memory loss Tremors Confusion Dizziness

Blood: Anemia Bleeding Excessive bruising Recurrent infections Nose bleeds

Additional Information (if applicable)

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