



OhioHealth

OhioHealth Surgical Specialists

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Patient:

Referring Physician:

DOB:

Appt Date:

Please complete the following questions regarding your allergies, medications, family history and past medical history:

ALLERGIES

Y N Are you allergic to any medications?

If so, please list medication and reaction

Allergic to:

Reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

Y N Are you taking any medications?

If so, please list medication, dose and frequency

Medication

Dose

Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

MARITAL

M S D W Marital Status

SMOKING

Y N Do you smoke?

_____ packs/day for _____ years

Quit smoking _____ years ago

ALCOHOL

Y N Do you drink alcohol?

_____ drinks/day for _____ years

Quit drinking _____ years ago

WOMEN'S HEALTH

Y N Birth control

Type: _____

_____	Date of last menstrual period
_____	Date of last Pap smear
_____	Date of last mammogram
_____	Number of pregnancies
_____	Number of live births

FAMILY HISTORY

Y N Diabetes

Y N Heart Disease

Y N High Blood Pressure

Y N Stroke

Y N Asthma

Y N Blood Clots

Y N Bleeding Disorders

Y N Thyroid Problems

Y N Breast Cancer

Y N Colon Cancer

Y N Other Cancer: _____

Y N Mental Illness

Other diseases that run in the family :

LIST ANY OTHER PAST HEALTH ISSUES:

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MEDICAL HISTORY		
GENERAL		
Y	N	Blood clots
Y	N	Bleeding disorder
Y	N	Diabetes
Y	N	Heart failure
Y	N	Murmur/valve disease
LUNGS		
Y	N	Asthma
Y	N	COPD
Y	N	Lung cancer
CIRCULATION		
Y	N	Stroke/TIA
Y	N	Aneurysm
Y	N	Claudication
SKIN, JOINTS AND MUSCLES		
Y	N	Skin cancer
Y	N	Arthritis
Y	N	Fibromyalgia
Y	N	Low back pain
INTESTINAL		
Y	N	Ulcers
Y	N	Esophageal Reflux
Y	N	Hiatal Hernia
Y	N	Diverticulitis
Y	N	Irritable Bowel
Y	N	Crohn's Disease
Y	N	Colon Polyps
Y	N	Hepatitis
Y	N	Hemorrhoids
Y	N	Anal fissure
Y	N	Colon Cancer
Y	N	Stomach Cancer
Y	N	Esophageal Cancer
BREAST		
Y	N	Fibrocystic disease
Y	N	Mastitis
Y	N	Breasts Cancer
UROLOGY/GYN		
Y	N	Kidney Stones
Y	N	Other Kidney Problems
Y	N	Prostate Problems
Y	N	Prostate Cancer
Y	N	Vaginal Bleeding
Y	N	Ovarian Cancer
Y	N	Cervix/Uterine cancer
OTHER MEDICAL PROBLEMS		

SURGICAL HISTORY		
ANESTHESIA		
Y	N	Gen. anesthesia
Y	N	Spinal/epidural
HEAD AND NECK		
Y	N	Tonsillectomy
Y	N	Thyroid surgery
HEART		
Y	N	Heart catheterization
Y	N	Angioplasty
Y	N	Coronary bypass
Y	N	Valve replacement
Y	N	Pacemaker
Y	N	Defibrillator
LUNGS		
Y	N	Bronchoscopy
Y	N	Lung biopsy
Y	N	Lung resection
INTESTINAL		
Y	N	Upper endoscopy
Y	N	Colonoscopy
Y	N	Appendectomy
Y	N	Gallbladder
Y	N	Ulcer surgery
Y	N	Colon resection
Y	N	Reflux surgery
Y	N	Adhesions
Y	N	Groin hernia
Y	N	Incisional hernia
BREAST		
Y	N	Breast biopsy
Y	N	Lumpectomy
Y	N	Mastectomy
UROLOGY/GYN		
Y	N	Tubal ligation
Y	N	C-section
Y	N	Hysterectomy
CIRCULATION		
Y	N	Carotid surgery
Y	N	Aortic surgery
SKIN, JOINTS AND MUSCLES		
Y	N	Arthroscopy
Y	N	Fracture surgery
Y	N	Joint replacement
Y	N	Back surgery
OTHER SURGICAL PROCEDURES		

