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Surgery Health History Questionnaire

IMPORTANT: Please complete this document as thoroughly as possible. All information is strictly confidential.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (last, first, MI):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     State:\_\_\_\_\_\_\_     Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Sex:  Female/ Male

Marital Status (circle one): Married/ Single/ Divorced/ Widowed

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Health Care Physician/MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    If referred, please give the name of who referred you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had acupuncture before: Y/N

If yes, from whom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by a Homeopath before? Y/N

If yes, from whom:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker or other implantable device: Yes No

What type of surgery will you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When is your surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your surgeon :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what facility will this occur:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you having surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain Y / N If so, where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate the pain : None 1 2 3 4 5 6 7 8 9 10 Worst

Is there anything else you would like to tell me about the surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History

Please check any of the following medical conditions you may have had or currently have by  marking a ‘P” for past condition and a ‘C’ for current condition. If past condition please  indicate when you had it.

\_\_\_\_\_\_\_ AIDS/HIV   \_\_\_\_\_\_\_ Fibromyalgia   \_\_\_\_\_\_\_ Multiple Sclerosis

\_\_\_\_\_\_\_ Alcoholism  \_\_\_\_\_\_\_ Drug Addiction   \_\_\_\_\_\_\_ Heart Disease

\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_ Stroke   \_\_\_\_\_\_\_ Polio

\_\_\_\_\_\_\_ Scarlet Fever   \_\_\_\_\_\_\_ Tuberculosis  \_\_\_\_\_\_\_ Jaundice

\_\_\_\_\_\_\_ Allergies(food, latex) \_\_\_\_\_\_\_ Rheumatic Fever  \_\_\_\_\_\_\_ Pneumonia

\_\_\_\_\_\_\_ Seasonal Allergies \_\_\_\_\_\_\_\_ Asthma     \_\_\_\_\_\_\_ Hepatitis

\_\_\_\_\_\_\_ Seizures/Epilepsy  \_\_\_\_\_\_\_ Migraines  \_\_\_\_\_\_\_ Birth Trauma

\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_ Joint Replacements  \_\_\_\_\_\_\_ Diabetes

\_\_\_\_\_\_\_ Anemia  \_\_\_\_\_\_\_ Thyroid Disorder  \_\_\_\_\_\_\_ Lyme’s Disease

\_\_\_\_\_\_\_ Emphysema    \_\_\_\_\_\_\_ Bleeding Disorder  \_\_\_\_\_\_\_ Mono

\_\_\_\_\_\_\_ Chicken Pox \_\_\_\_\_\_\_ Cold Sores \_\_\_\_\_\_\_ STD

\_\_\_\_\_\_\_ Emphysema \_\_\_\_\_\_\_ Other Lung illnesses \_\_\_\_\_\_\_ Other Liver illnesses

\_\_\_\_\_\_\_ Other Heart illnesses  \_\_\_\_\_\_\_ Other Kidney illnesses

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any major injuries you may have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What vaccinations have you had: \_\_\_\_\_ Tetanus- Date:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Shingles- Date:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Pneumonia- Date:\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Meningitis- Date:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Gardisil- Dates:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Chicken Pox -Date:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Hepatitis B- Dates:\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Hepatitis A- Dates:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_MMR- Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Influenza – Date:\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any adverse reactions to them? Please list information below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women Only:

Pregnant Y / N

Menopause Y / N

Last Menstrual Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies\_\_\_\_\_ Miscarriages\_\_\_\_\_ Abortions\_\_\_\_\_

Last Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone Density Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History

Please list any major surgeries you may have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are over 50, have you had a colonoscopy? Y / N If so, when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications and Supplements

Please list all prescribed and over the counter medications, supplements, and vitamins you  are currently taking routinely. Indicate the dosage and reason for taking, as well. Write on the back of the sheets if needed.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_ purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_   purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_    purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_  purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dosage \_\_\_\_\_\_\_\_\_\_   purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If additional medications, please list on the back of this form.

Allergies

Are you allergic to any medications : Y / N

Are you allergic to any supplements/herbs: Y / N

Are you allergic to any food: Y / N

Are you allergic anything in the environment: Y / N

Are you allergic to anything else: Y / N

If so, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History

Relative Alive Health Conditions/Cause of Death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother Y / N

Father Y / N

MGF Y / N

MGM Y / N

PGF Y / N

PGM Y / N

Sister Y / N

Brother Y / N

Other Y / N

Diet & Lifestyle

Do you drink caffeine:  Y / N     how much: \_\_\_\_\_\_\_\_\_  coffee / tea / soda/ energy drinks

Do you drink alcohol:  Y / N       how much: \_\_\_\_\_\_\_\_\_

Do you smoke: Y / N      how much: \_\_\_\_\_\_\_\_\_

Do you chew tobacco: Y / N how much: \_\_\_\_\_\_\_\_\_\_

Do you do recreational drugs: Y / N which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of Systems

Present Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Weight one year ago:\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maximum weight and when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Minimum weight as adult & when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ideal Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REGARDING THE NEXT SECTION: Please circle (Y) if you have the problem NOW, (N) if you’ve NEVER had the problem, (P) if you had the problem in the PAST.

Good Energy: Y N P Fatigue: Y N P

If you have fatigue, when is it the worst:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have fatigue, can you do what you need to during the day? Y N

*SKIN*

Rash: Y N P Color Change: Y N P Hives: Y N P Lump: Y N P

Psoriasis/eczema: Y N P Itchy: Y N P Dry: Y N P Warts/moles: Y N P

Cancer: Y N P Perspiration: Y N P

*HEAD*

Headache: Y N P Migraine: Y N P Dandruff: Y N P

Head Injury: Y N P Oil/dry hair: Y N P Hair loss: Y N P

*NOSE*

Frequent Colds: Y N P Nosebleeds: Y N P Congestion: Y N P

Post Nasal Drip: Y N P Polyps: Y N P Seasonal Allergies: Y N P

*EYES*

Dry/Watery: Y N P Blurry Vision: Y N P Double Vision Y N P

Cataracts: Y N P Glaucoma: Y N P Styes: Y N P

Strain: Y N P Discharge: Y N P Itchy: Y N P

Dark under Eyelid: Y N P

*MOUTH/THROAT*

Canker sores: Y N P Cold sores: Y N P Sore Throat: Y N P

Gum disease: Y N P Dentures: Y N P Cavities: Y N P

Loss of taste: Y N P Hoarseness: Y N P

*NECK*

Stiffness: Y N P Tension: Y N P Full movement: Y N P

Swollen Glands: Y N P

*RESPIRATORY*

Cough: Y N P TB: Y N P Shortness of breath w/ exertion: Y N P

Bronchitis: Y N P Pneumonia: Y N P Shortness of breath lying down: Y N P

Asthma: Y N P Wheezing: Y N P Shortness of breath sitting: Y N P

Painful breathing: Y N P

*CARDIOVASCULAR*

High Blood Pressure: Y N P Murmurs: Y N P Rheumatic Fever: Y N P

Low Blood Pressure Y N P Arrhythmias: Y N P Palpitations: Y N P

Edema: Y N P Chest Pain: Y N P

URINARY TRACT

Incontinence: Y N P Kidney Stones Y N P Pain w/ Urination Y N P

Frequent Infections: Y N P Urgency: Y N P Discharge/Blood: Y N P

*GASTROINTESTINAL*

Heartburn: Y N P Bowel Movement Freq:

Indigestion: Y N P Recent BM Change: Y N P Bloating: Y N P

Nausea: Y N P Diarrhea/Constipation: Y N P Hemorrhoids: Y N P

Vomiting: Y N P Gall Bladder Disease Y N P Change in Appetite: Y N P

Liver Disease: Y N P Pancreatitis: Y N P Ulcer Y N P

*MALE GENITALIA*

Sexually Active: Y N P Testicular pain/swelling: Y N P Hernia: Y N P

S.T.D.: Y N P Discharge: Y N P Impotency: Y N P

Prostate Disease/Symptoms: Y N P Sexual Orientation: Hetero Homo Bi

*FEMALE GENITALIA*

Age Period Began: How Often Period Occurs: How long period lasts:

Heavy menstrual bleeding: Y N P Menstrual cramping: Y N P Menstrual Pain: Y N P

PMS: Y N P Food cravings: Y N P

Any abnormal paps: Y N P When was abnormal:

Menopausal since what age: Use of hormones: Y N P Type of hormones used:

Healthy libido: Y N P Dry vagina: Y N P Sexually Active: Y N P

Pain w/ Intercourse: Y N P Vaginitis: Y N P S.T.D.: Y N P

Please list any birth control used and ages used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that all the above information is correct and I have listed all of my medical issues to the best of  my ability. Janine Maere, MD is not responsible for the aggravation of any conditions which were present but weren’t disclosed to the practitioner at the  time of treatment.  I take responsibility to inform my practitioner if there are any changes to my  physical, psychological, or emotional state.

Signature X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_