

PATIENT INFORMATION



Date: _____

PERSONAL INFORMATION		
Name:	Birth Date:	Age:
Mailing Address:		
City:	State:	Zip:
Street Address (if different):		
SS#	Marital Status:	
Home Phone:	Cell #:	
Employer:	Occupation:	
Work Phone:	E-mail:	
Primary Care Doctor:		
Referring Doctor:		

SPOUSE OR GUARDIAN INFORMATION	
Name:	Relationship to patient:
Employer:	Occupation:
Work Phone:	
SS#:	Birth Date:

MEDICAL INSURANCE INFORMATION	
Insurance Co:	Insured's Name:
ID#:	Group #:
Secondary Medical Insurance Information	
Insurance Co:	Insured's Name:
ID#:	Group #:

EMERGENCY CONTACTS LIST Please list people that you would allow our office to contact or release medical information to:

Name:	Phone number:	Cell number:	Relation to you:
1.			
2.			
3.			



MEDICAL HISTORY QUESTIONNAIRE

DATE _____ FULL NAME _____

Sex: M F Birthdate _____ Age _____

Who referred you to our office? _____

What is the chief reason that you are consulting a surgeon? _____

Please circle any medical diseases for which you are now being treated now, have been treated in the past, or for which you have been admitted to the hospital:

- | | | |
|---------------------|-----------------------------------|--------------------|
| High blood pressure | Aneurysm | Thyroid Disease |
| Heart attack | Vascular disease | Hepatitis A B or C |
| Angina | Hyperlipidemia / High cholesterol | MRSA |
| Chest pain | Arthritis - Rheumatoid -- Osteo | Diabetes |
| Asthma/COPD | Atrial Fibrillation | HIV/AIDS |

FEMALES: Age started menstruating? _____ # of pregnancies _____ # of deliveries _____
of c-sections _____ Date of last normal period _____ Hormone therapy _____
What was your age when you had your first live birth? _____

OPERATIONS:

<u>SURGERY NAME</u>	<u>DATE</u>	<u>HOSPITAL, CITY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS:

<u>MEDICATION NAME</u>	<u>TYPE OF RESPONSE</u>
_____	_____
_____	_____

Have you ever had any anesthetic complications? _____

Have you ever had a life-threatening reaction to medication? _____

Physician Review _____ Date _____

MEDICATION LIST			
Allergic to _____			
Patient Name _____		Date _____	DOB _____
Name of Medication	Strength	Dosage	Dr. Prescribing
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

Over-The-Counter Medications: Include any you are taking regularly		
Name	Strength	Dose You Take
1.		
2.		
3.		
4.		
5.		

