

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 _____

FAMILY HISTORY:

	<u>LIVING</u>	<u>AGE</u>	<u>CHIEF MEDICAL DISEASES</u>
Mother	Y N	_____	_____
Father	Y N	_____	_____
Brother	Y N	_____	_____
Brother	Y N	_____	_____
Sister	Y N	_____	_____
Sister	Y N	_____	_____

Circle diseases that tend to run in your family:

- Diabetes
- Strokes
- Other _____
- High blood pressure
- Cancer
- Heart attacks
- Bleeding disorders

SOCIAL HISTORY:

Do you smoke? Y N Packs per day? _____ How long? _____ When did you stop? _____

Do you drink alcohol? Y N Type? _____ How much? _____ How often? _____

Do you drink Coffee? Y N How much? _____ How often? _____

What type of work do you do, or have you done most of your life? _____

Please circle if you have the following current symptoms or problems:

HEENT

- Trouble with your eyes
- Seasonal allergies

CARDIOVASCULAR

- Chest pain on exertion
- Chest tightness on exertion
- Angina
- Chronic ankle swelling
- Difficulty breathing when lying flat
- Fainting spells

PULMONARY

- Shortness of breath on exertion
- Recurrent lung infections
- Cough up blood

GI

- Significant weight gain
- Significant weight loss
- Frequent nausea
- Frequent vomiting
- Frequent diarrhea
- Frequent constipation
- Change in bowel habits
- Change in stool size
- Black tarry stools
- Hemorrhoids

GI, CONT.

- Hernias
- Peptic ulcer disease
- Vomiting blood

GU

- Urinary incontinence
- Burning w/ urination

MUSCULOSKELETAL

- Chronic back pain

SKIN

- Concerning skin lesions

NEUROLOGIC

- Seizures
- CVA (cerebrovascular accident)
- TIA (stroke)
- Loss of strength or sensation on one side

ENDOCRINOLOGY

- Thyroid problems
- Diabetes

HEMATOLOGY

- Bleeding problems
- Blood clots

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.		



CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION Oregon Surgical Specialists, PC

I authorize Oregon Surgical Specialists, PC to use and disclose the information of _____ for the purposes defined below:
Printed Patient Name

Treatment includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefits claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization. Also includes billing information shared with from the hospital or surgery center.

Health Care operations include the necessary administrative and business functions of our office.

You may review Oregon Surgical Specialists, PC detailed and extended "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this consent prior to signing this consent. This copy is posted in our waiting room on the "resource center" board.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change from time to time.

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that Oregon Surgical Specialists, PC has already used or disclosed the information in reliance on this consent.

Date

Signature of Patient (or)

Date

Signature of Legal Representative