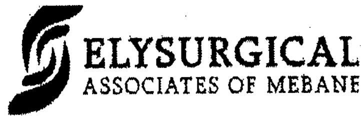

PATIENT INFORMATION FORM

Today's Date: ____________________

Last Name: ____________________ First Name: ____________________ Middle Initial :________

Home Address: ____________________ Home Phone: ____________________

City: ____________________ State: ____________________ Zip Code:____________________

Mailing Address (If different from above): ____________________

Email: ____________________ Cell Phone: ____________________

Date of Birth: ____________________ Sex ( ) Male ( ) Female Marital Status: ____________________

Race: _____ American Indian or Alaska Native _____Asian ______Black or African American
_____ Native Hawaiian or Other Pacific Islander _____White ______Declines to Answer

Ethnicity: ______ Hispanic or Latino ______ Not Hispanic or Latino _______Declines to Answer

Preferred language spoken: ____________________ Driver's License Number: ____________________

Social Security #: ____________________ Occupation: ____________________

Employer Name & Address: ____________________ Work Phone: ____________________

Spouse Information: Name ____________________ Date of Birth__________Cell # ____________________

Employer Name & Address ____________________ Work Phone____________________

Please list the adult responsible for payment if patient is a minor or dependent.

Name: ____________________ Date of Birth:__________ Relation to Patient:__________

Home Address: ____________________ Home Phone: ____________________

Employer Name & Address:____________________ Work Phone: ____________________

Do you have a living will? Yes ______________ No ____________

Do you have a health care power of attorney? Yes ____________ No ____________

If yes, please list name and phone #: ____________________

Referring Physician? ____________________ Primary Care Physician? ____________________

Pharmacy Preference & location? ____________________

Please list the name and phone# of any individuals you are giving permission to receive information about the care of the above named patient.

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Reason for your visit: ______________________________

Prior Surgeries and year: ______________________________

____

Medical History:

Heart Disease	No Yes ________		High Blood Pressure	No Yes ________
Diabetes	No Yes ________		Peptic Ulcer Disease	No Yes ________
Hepatitis	No Yes ________		Pancreatitis	No Yes ________
Stroke	No Yes ________		Lung Disease	No Yes ________
Cancer	No Yes ________		Seizures	No Yes ________

Current Medications ***(***please bring all medications with you to your appointment***)***

Use separate sheet if necessary

Name of medication	*Dosage*	*How many times per day*

Allergies to medications:

Name of Medication	Type of Reaction	Name of Medication	Type of Reaction

Have you ever smoked cigarettes or cigars? ________ Do you currently smoke? ________

If not, when did you quit? ________ If so, how many pack (s) a day? ________

Use of alcohol? Never ______ If yes, what type (wine, beer, liquor) Average # drinks per week? ______

Family History:

	Relationship		*Relationship*
Heart Disease	No Yes ________	High Blood Pressure	No Yes ________
Diabetes	No Yes ________	Peptic Ulcer Disease	No Yes ________
Hepatitis	No Yes ________	Pancreatitis	No Yes ________
Stroke	No Yes ________	Lung Disease	No Yes ________
Cancer	No Yes ________	Seizures	No Yes ________

Height ________ **Weight** ________ **BP** ________ **P** ________ **T** ________

I hereby authorize payment from my insurance company directly to Ely Surgical and accept full responsibility for any portion of the charge not paid for by my insurance company for all services rendered to me in the course of my treatment. I authorize Ely Surgical to release to my insurance company any information acquired in the course of my examination and treatment regarding my condition.

Insured Signature ______________________ Date ______________

I have reviewed a copy of Ely Surgical's Notice of Privacy Practices. I may request a copy for my records.

Patient Signature ______________________ Date ______________

REVIEW OF SYMPTOMS

NAME: ______________________________ ***DOB:*** ______________

DATE COMPLETED: ____________________

INDICATE BELOW ANY SYMPTOMS **YOU ARE CURRENTLY HAVING:**

1. GENERAL:	Yes	No
Chills	___	___
Fatigue	___	___
Fever	___	___
Weight Gain	___	___
Weight Loss	___	___

2. SKIN:	Yes	No
Bruising	___	___
New Lesions	___	___
Rash	___	___

3. HEENT:	Yes	No
Headache	___	___
Blurred Vision	___	___
Double Vision	___	___
Visual Loss	___	___
Hearing Loss	___	___
Ear Pain	___	___
Noise in Ears (Tinnitus)	___	___
Dizziness(Vertigo)	___	___
Nose Bleed	___	___
Nasal Congestion	___	___
Seasonal Allergies	___	___
Hoarseness	___	___
Sore Throat	___	___
Decreased Taste	___	___

4. NECK:	Yes	No
Neck Mass	___	___
Neck Pain	___	___
Neck Stiffness	___	___

5. RESPIRATORY:	Yes	No
Cough	___	___
Snoring	___	___
Sputum Production	___	___
Shortness of breath	___	___
Wheezing	___	___

7. CARDIOVASCULAR:	Yes	No
Chest Pain	___	___
Irregular Heart Beat	___	___
Leg Pain and/or Swelling	___	___
Palpitations	___	___

8. GASTROINTESTINAL:	Yes	No
Abdominal Mass	___	___
Abdominal Pain	___	___
Heartburn	___	___
Bloating	___	___
Change in Bowel Habits	___	___
Constipation	___	___
Diarrhea	___	___
Difficulty Swallowing	___	___
Food Intolerance	___	___
Indigestion	___	___
Nausea	___	___
Rectal Bleeding	___	___
Vomiting	___	___

9. MUSCULOSKELETAL:	Yes	No
Back Pain	___	___
Joint Pain	___	___
Muscle Weakness	___	___
Swelling of Extremities	___	___

10. NEUROLOGY:	Yes	No
Fainting	___	___
Headaches	___	___
Numbness	___	___
Seizures	___	___
Stroke	___	___
Weakness	___	___

11. PSYCHIATRIC:	Yes	No
Anxiety	___	___
Depression	___	___
Nervousness	___	___

12. HEMATOLOGY:	Yes	No
Easy Bruising	___	___
Easy Bleeding	___	___

13. GYN: (for females only):	Yes	No
Last menstrual period	__________ (date)	
Regular cycles/periods?	___	___
Do you use birth control?	___	___
Type ______________________		

Name: ______________________ **DOB:** ____________________

PAST HISTORY

	YES	NO		YES	NO
Problems with General Anesthesia	___	___	Previous Surgery	___	___

INDICATE BELOW ANY HISTORY OF DISEASES YOU HAVE HAD

Medical Illnesses:	YES	NO		YES	NO
Lung Disease	___	___	Hypertension (High Blood Pressure)	___	___
Asthma	___	___	Urinary Disease	___	___
Heart Disease	___	___	Pelvic Disease	___	___
Blood Vessel Disease	___	___	Prostate Disease	___	___
Glaucoma	___	___	Kidney Disease	___	___
Arthritis	___	___	Diabetes	___	___
Bleeding Tendency	___	___	Hepatitis	___	___
Seizures	___	___			

List any other health conditions ____

FAMILY HISTORY

INDICATE BELOW THE DISEASE IN YOUR PARENTS, BROTHERS OR SISTERS

	YES	NO		YES	NO
Cancer	___	___	Hearing Loss	___	___
Heart Disease	___	___	Bleeding Abnormalities	___	___
Hypertension (High Blood Pressure)	___	___	Anesthesia Complications	___	___
Lung Disease	___	___	Allergies	___	___

List any other health conditions ____

SOCIAL HISTORY

Current or Previous Occupation: ____

	YES	NO	
Are you pregnant?	___	___	
Caffeine Use?	___	___	
Alcohol Use?	___	___	Amount ____________ per week
Recreational Drug Use	___	___	
Tobacco Use?	___	___	

Year quit_____ If smoking, type of tobacco______________ #_____ of packs per day for #_____ years.

The above information is correct.

Patient Signature: ______________________________ **Date:** ______________

I have reviewed both sides of this medical history form.

Physician Signature: ______________________________ **Date:** ______________