

PATIENT DEMOGRAPHICS

TODAY'S DATE _____

PATIENT NAME _____ BIRTH DATE _____ AGE _____ ACCT # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ BUSINESS PHONE (____) _____ SEX ___M___F

SOCIAL SECURITY NUMBER ____/____/____ DRIVERS LICENSE _____

MARITAL STATUS ___M___D___S___W EMPLOYED BY _____

E-MAIL ADDRESS _____ CELL # _____

REFERRED BY _____

PRIMARY

INSURANCE COMPANY _____ ID# _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED PERSON'S NAME _____ EMPLOYED BY _____

SOCIAL SECURITY NUMBER ____/____/____ DATE OF BIRTH _____

SECONDARY

INSURANCE COMPANY _____ ID# _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED PERSON'S NAME _____ EMPLOYED BY _____

SOCIAL SECURITY NUMBER ____/____/____ DATE OF BIRTH _____

PERSON NOT LIVING WITH YOU TO CONTACT IN AN EMERGENCY _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ BUSINESS PHONE (____) _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including MEDICARE, private insurance and any other health plans to: Suburban Surgical Care Specialists, S.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event that the patient fails to make payment or there is an outstanding obligation on the account, the patient hereby agrees to be responsible for all court costs and reasonable attorney fees in regards to the collection of this account.

SIGNED _____ DATE _____

PATIENT NAME _____ **DATE** _____

HISTORY OF PRESENT ILLNESS:

Purpose of this visit _____

What symptoms are you having? For how long? _____

MEDICAL HISTORY: Procedure and Date

_____	_____
_____	_____
_____	_____

SURGICAL/HOSPITALIZATION HISTORY:

Date of surgery or hospitalization

Complications? Problems w/anesthesia?

_____	_____
_____	_____
_____	_____

MEDICATIONS: List all medications, dosages and times taken per day.

_____	_____
_____	_____
_____	_____

Do you take aspirin? _____ Yes _____ No How much? _____

ALLERGIES: Medications/Foods What was your reaction?

_____	_____
_____	_____

SOCIAL HISTORY: Occupation _____

Cigarettes or tobacco _____ Yes _____ No How much/how often? _____

Alcohol _____ Yes _____ No How much/how often? _____

Drugs _____ Yes _____ No How much/how often? _____

	Yes	No
GENERAL		
Good general health lately	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>

EYES		
Eye disease or injury	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>

EAR, NOSE, MOUTH, THROAT		
Hearing loss or ringing	<input type="checkbox"/>	<input type="checkbox"/>
Earaches or drainage	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath or bad taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Laryngitis	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR/HEART		
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of feet, ankles and hands	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY		
Chronic or frequent coughs	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL		
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Painful bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
GENITOURINARY		
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Burning or painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Change in force or stream when urinating	<input type="checkbox"/>	<input type="checkbox"/>

Incontinence or dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Male – testicular pain	<input type="checkbox"/>	<input type="checkbox"/>
Female - pain with periods irregular periods vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL		
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness or swelling	<input type="checkbox"/>	<input type="checkbox"/>
Weakness of muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Cold extremities	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in walking	<input type="checkbox"/>	<input type="checkbox"/>

SKIN		
Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>
Change in hair or nails	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL		
Frequent/recurring headaches	<input type="checkbox"/>	<input type="checkbox"/>
Lightheaded or dizzy	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine		
Glandular/hormone problem	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Skin becoming drier	<input type="checkbox"/>	<input type="checkbox"/>
Change in hat or glove size	<input type="checkbox"/>	<input type="checkbox"/>

HEMATOLOGIC/LYMPHATIC		
Slow to heal after cuts	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Past transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY MEDICAL HISTORY:

RELATIONSHIP

	Living	Deceased	Age	Diseases
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you or any of your family members have a history of bleeding problems _____ Yes _____ No

Date of last test for colon cancer _____

Relatives with colon cancer _____

Date of last EKG _____ Chest X-Ray _____

FOR WOMEN ONLY

Age of first menstrual period _____ Age of menopause _____ Date of last Pap Smear _____

Age of first pregnancy _____ Number of pregnancies _____ Date of last mammogram _____

Relatives with breast cancer _____

History of hormone use (i.e. estrogen, oral contraceptives) _____

AUTHORIZATION: To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the medical office of any changes in my medical status.

Signature of Patient or Guardian

Date

Signature of Physician

Date