New General Surgery Patient Intake Form

Please answer all questions to the best of your ability. **For claims to be submitted to insurance, the entire 1st. page must be completed.**

Date:

PATIENT INFORMATION Patient name:	Male Female
Birth date : **Soc. Sec. no.:**	Marital status: S M D W
Mailing address: Apt no.:	
City: State: Zip:	
Home Phone#: **Cell Phone# :**	
Email Address:	
Reason for this visit:	
Height: ft. in. **Weight**: lbs.	
EMPLOYER INFORMATION: Full Time Unemployed Student Retired Disability Employer/School name:	
Patient occupation: Work phone no:	
Employer address:	
City: State: Zip:	
PRIMARY INSURANCE INFORMATION Carrier/Plan: Phone no:	
Address:	
City: State: Zip:	
Policy #:	Group no.:
Name of insured:	Insured's birth date:
Insured's mailing address:	
City: State: Zip:	
Insured's Soc. Security no.: Patient's relationship to insured:	
Insured's employer: Insured's occupation:	
SECONDARY INSURANCE INFORMATION None Carrier/Plan: Phone no:	
Address:	
City: State: Zip:	
Policy #:	Group no.:
Name of insured:	Insured's birth date:
Insured's mailing address:	
City: State: Zip:	
Insured's Soc. Security no.: Patient's relationship to insured:	
Insured's employer: Insured's occupation:	

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New **General Surgery** Patient Intake Questionnaire

In order to minimize your wait time and maximize your experience, please take a moment to complete this questionnaire. We realize this is a lengthy form but assure you it is all important information and will be kept confidential.

Date_____

First Name: _____**Last Name:** _____DOB:_____

What are you here for today?

_____

_____

_____

_____

_____

_____

Who referred you to our practice? Dr._____ SELF

Please list all Doctor's you follow up with:

_____

_____

_____

_____

Medications: Please list below any and all medications/vitamins you are currently taking.

Example: Lipitor 10mg one tablet daily at bedtime

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

❑ Not currently taking any medications

Allergies: Do you have allergies to any of the following:

❑ Medications, if so, please **list medication and reaction**:

❑ _____

_____

_____

❑ Latex

❑ Iodine, when: _____

❑ IV Contrast, when: _____

❑ Adhesives, type: _____

❑ No Known Allergies

Medical History

Please carefully review the list of medical conditions/problems listed below and check any that apply to you:

- ❑ Angina
- ❑ Allergic Rhinitis
- ❑ Anxiety
- ❑ Asthma
- ❑ Breast Cancer
- ❑ Heart Disease w/bypass surgery
- ❑ Heart Disease without bypass surgery
- ❑ Cardiomyopathy
- ❑ Carpal Tunnel Syndrome
- ❑ Chest pain with exertion/exercise
- ❑ Gallstones
- ❑ Chronic Back Pain
- ❑ Congestive Heart Failure
- ❑ Stroke
- ❑ DVT (Blood Clot)
- ❑ Degenerative Disk Disease
- ❑ Depression
- ❑ Type I Diabetes/Insulin Dep (controlled)
- ❑ Type I Diabetes/Insulin Dep (Uncontrolled)
- ❑ Type II Diabetes/Adult Onset (Controlled)
- ❑ Type II Diabetes/Adult Onset (Uncontrolled)
- ❑ Abnormal Uterine Bleeding
- ❑ Dysmenorrhea (Excessively painful menses)
- ❑ Shortness of breath with exertion/exercise
- ❑ Abnormally elevated liver function tests
- ❑ Fatigue
- ❑ Fatty liver (due to alcohol)
- ❑ Fatty liver (NOT related to alcohol)
- ❑ Fibrocystic breast disease
- ❑ Fibromyalgia
- ❑ Acid Reflux Disease/GERD
- ❑ Gestational Diabetes (diab w/pregnancy)
- ❑ Glucose Intolerance
- ❑ Gout
- ❑ Heartburn/Indigestion
- ❑ Hemorrhoids
- ❑ High Cholesterol
- ❑ Hypertension (high blood pressure)
- ❑ High triglycerides
- ❑ Hypothyroidism (Underactive thyroid)
- ❑ Infertility
- ❑ Insomnia
- ❑ Intermittent Claudication
- ❑ Intertriginous Dermatitis (irritation of the skin folds)
- ❑ Irritable Bowel Syndrome
- ❑ Joint Pain
- ❑ Menstrual Irregularity
- ❑ Migraine Headaches
- ❑ Myocardial Infarction (Heart Attack)
- ❑ Swelling of the legs (edema)
- ❑ Peripheral Vascular Disease
- ❑ Stomach Ulcers
- ❑ Polycystic Ovarian Syndrome (PCOS)
- ❑ Pseudotumor Cerebrii
- ❑ Pulmonary Embolus (blood clot to lungs)
- ❑ Seasonal Allergies
- ❑ Sleep Apnea
- ❑ Sleeping Disorder
- ❑ Stress Urinary Incontinence (leaking urine with cough/straining)
- ❑ Thrombophlebitis
- ❑ Urinary Urge Incontinence (can't hold urine)
- ❑ Varicose Veins
- ❑ Venous Insufficiency

❑ Other: _____

Surgical History:

Please list Surgeries ❑ No prior surgeries

Example: Open Hysterectomy w/ ovaries removed, 1/25/99, no complications

****specify Laparoscopic or Open** Date: Complications:

Please list previous ***bariatric*** (weight loss) surgeries: ❑ No prior ***bariatric*** surgeries

Procedure/Surgery: Gastric Band placement/removal, Gastric ByPass, Gastric Sleeve, Revision

(laparoscopic/Open)	**Date:**	**Original Weight:**	**Lowest Weight**	**Complications:**

Family History: (Please include only parents, grandparents, and siblings)

Illness/Medical Condition	Family Member

Social History:

Do you currently smoke? ❑ Yes ❑ No

If yes, how many years have you been smoking? _____ Packs per day? _____

For past smokers, what year did you quit? _____How many years did you smoke? _____

Do you drink alcohol? ❑ Yes ❑ Occasionally ❑ No

If yes, how many times/week or month? _____

Do you use illicit/street drugs? ❑ Yes ❑ No

If yes, what type did/do you use and how often? _____

Review of Symptoms:

Please review and circle any symptoms that CURRENTLY apply.

General: no problems, fevers, sweats, chills, weight loss, excessive weakness, fatigue

Neurologic: no problems, tremors, focal neurologic symptoms, visual disturbances, headaches, fainting, blackout, numbness or loss of sensation, tingling, paralysis.

Psychiatric: no problems, nervousness (anxiety), tension, depression, memory problems

Eyes: no problems, blurry vision, glasses, pain, excessive tearing, spots, specks

Ears: no problems, ringing in ears, dizziness, room spinning, earache, drainage from ear, hearing aids

Nose/Sinus: no problems, nasal stuffiness, frequent colds, earache, infection, discharge

Mouth/Throat: no problems, bleeding gums, sore throat, dry mouth, sores, hoarseness

Neck: no problems, lumps, swollen glands, pain, stiffness, goiter

Cardiac: no problems, fainting (syncope), heart trouble, heart murmur, chest pain, palpitations, shortness of breath, shortness of breath when lying flat

Respiratory: no problems, cough, sputum, wheezing, painful breathing (Dyspnea).

Endocrine: no problems, heat/cold intolerance, excessive sweating, excessive thirst or hunger, excessive urination

GI: no problems, heartburns, constipation, diarrhea, indigestion, nausea, vomiting, abdominal pain, vomiting of blood, black stool, rectal bleeding, yellow skin (Jaundice).

Hematology: no problems, easy bruising or bleeding, hyper coagulations, blood clots (DVT, PE), Anemia.

Vascular: no problems, DVT, leg pain, cramps, varicose veins, blood clots, swelling_____

Kidney/Genitourinary: no problems, burning with urination, blood in urine, change in frequency of urination, incontinence, flank pain, pelvic pain.

Musculoskeletal: no problems, back pain, muscle ache, fibromyalgia, joint swelling/pain(arthritis), joint deformities, abdominal/inguinal bulge/lumps (hernias)

_____

Extremities (Arms, Legs): no problems, muscle weakness, joint pain, stiffness, backache, swelling_____

Skin: no problems, keloid scars, rash, color changes, yellow skin (Jaundice), change in hair or nails, lesions, cellulitis, lumps_____