HEI JIN CHUNG, M.D.

General and Vascular Surgery

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PATIENT REGISTRATION

Today's Date _____

PLEASE PRINT *Please complete all of the information on this form.*

Patient's Full Name _____ Age _____

Home Address _____

City _____ State _____ Zip _____

Home Phone # _____ Mobile Phone # _____ Email _____

Patient's Date of Birth _____ Social Security Number _____

Sex ❑ M ❑ F Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

The government is requiring the following:

Race: ❑ African American ❑ White ❑ Asian ❑ Native American ❑ Other _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Decline Primary Language: _____

Patient's Employer _____

Patient Employer Address _____

City _____ State _____ Zip _____

Employer Phone # _____ Extension _____

Patient's Spouse Name _____ DOB _____ Spouses Social Security Number _____

Emergency Contact _____ Phone _____

Primary Care/Family Physician _____ Physician's Phone Number _____

Physician's Address _____ City _____ State _____ Zip _____

Who Referred you to our office? _____ Reason for your visit today _____

Please List ALL Allergies: _____

Have you had previous treatment for the reason you are here today? ❑ No ❑ Yes _____

Medical History: Please check yes or no

High Cholesterol	❑ Yes ❑ No	Heart pacemaker	❑ Yes ❑ No	Back Pain	❑ Yes ❑ No
High Tryglycerides	❑ Yes ❑ No	Edema	❑ Yes ❑ No	Sleep Apnea	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	(swelling of extremities)		Thyroid Disorder	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Do you smoke?	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	HIV Positive	❑ Yes ❑ No	Do you drink Alcohol?	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Cancer (if yes where?)	❑ Yes ❑ No	Are you pregnant?	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No				
DVT (blood clot)	❑ Yes ❑ No	_____		Date of last menstrual period	_____

Past Surgical History (Please List all surgeries)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List All Medications:

Medication	Dosage	How Often