WELCOME TO OUR OFFICE Today's Date:_____

Thank you for choosing our office. In order to serve you properly, we will need the following information: (Please Print). All information will be strictly confidential.

Patient's Name:_____

Birth Date:_____Age_____Male_____Female_____

Marital Status: Single_____Married_____Widowed_____Divorced_____

Patient's Address:_____

_____

City State

Zip

Home Phone Number:(_____)_____

Business/Cell Phone Number:(_____)_____

Patient's Social Security Number:_____

E-Mail:_____

Race: African American_____American Indian_____Asian_____Caucasian_____

Native Hawaiian/Pacific Islander_____Other_____

Ethnicity:_____Preferred Language:_____

Do you need an interpreter: Y N

Name of Spouse:_____Birth Date:_____

Patient's Occupation:_____

Name of Employer:_____

Address of Employer:_____

PLEASE GIVE RECEPTIONIST INSURANCE CARD AND LICENSE TO COPY

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. FURTHERMORE, I AUTHORIZE THIS OFFICE TO RELATE OUR EVALUATION TO OTHER PHYSICIANS PROVIDING CARE TO ME THAT WILL ENHANCE CONTINUITY OF CARE.

Patient or Guardian Signature_____

REVIEW OF SYSTEMS: (please check if applicable)

CONSTITUTIONAL
- Fever_____
- Chills _____
- Weight Loss_____
- Fatigue_____
- Sweats_____
- Weakness_____

SKIN
- Rash_____
- Itching_____
- Jaundice_____

HENT:
- Headaches_____
- Hearing loss_____
- Ringing in ears_____
- Ear pain_____
- Nosebleeds_____
- Congestion_____
- Sore throat_____

EYES:
- Blurred vision_____
- Double vision_____
- Photophobia_____

MUSCULOSKELETAL
- Myalgias_____
- Neck pain_____
- Back pain_____
- Joint pain_____
- Falls_____

NEUROLOGICAL
- Dizziness_____
- Tingling_____
- Tremor_____
- Sensory change_____
- Speech change_____
- Focal weakness_____
- Seizures_____

CARDIOVASCULAR
- Chest pain_____
- Palpitations_____
- Shortness of breath_____
- Claudication_____
- Leg swelling_____

RESPIRATORY:
- Cough_____
- Shortness of breath_____
- Wheezing_____

GASTROINTESTINAL
- Heartburn_____
- Nausea_____
- Vomiting_____
- Abdominal pain_____
- Diarrhea_____
- Constipation_____
- Blood in stool_____

GENITOURINARY
- Pain or burning_____
- Urgency_____
- Frequency_____
- Blood in urine_____

PSYCHIATRIC
- Depression_____
- Suicidal ideas_____
- Substance abuse_____
- Hallucinations_____
- Nervous/anxious_____
- Insomnia_____
- Memory loss_____

Patient Name:_____Date_____
Height:_____Weight:_____

Past Medical History (please circle response for each question)

Diabetes Y or N	<u>If yes, please answer questions below</u> Insulin Y or N Neuropathy Y or N Retinopathy Y or N Diabetic pills Y or N Nephropathy Y or N		
High blood pressure	Y or N	Hepatitis	Y or N
High cholesterol	Y or N	Liver disease	Y or N
Cancer (list type)	Y or N	Headache (list type)	Y or N
High triglycerides	Y or N	Asthma	Y or N
Obstructive sleep apnea Snoring C.Pap/BiPap	Y or N	Psychiatric hospitalizations	Y or N
Joint pain (circle areas) Low back, hip, knee, ankle Foot, hands, shoulder, other.	Y or N	Bowel disease (colitis, irritable Bowel, etc.)	Y or N
Depression	Y or N	Kidney disease	Y or N
Heartburn/reflux	Y or N	Kidney stones	Y or N
Hiatal hernia	Y or N	Seizures	Y or N
Heart attack	Y or N	Skin disorder	Y or N
Heart failure	Y or N	Stroke	Y or N
Irregular heart rate	Y or N	Ulcers	Y or N
Chest pain or angina	Y or N	TB	Y or N
Bladder incontinence	Y or N	Hypoglycemia	Y or N
Leg/ankle swelling	Y or N	Varicose veins	Y or N
Blood clot or phlebitis (DVT)	Y or N	Gout	Y or N
Pulmonary embolus (blood clot In lung)	Y or N	Rheumatic fever	Y or N
Gallstones or gallbladder problems	Y or N	Blood in stool	Y or N
Shortness of breath with activity	Y or N	Crohn's disease	Y or N
Anemia	Y or N	Ulcerative colitis	Y or N
Anesthetic reaction	Y or N	Obesity	Y or N
Bleeding problem	Y or N	Glaucoma	Y or N
COPD/emphysema	Y or N	Home oxygen	Y or N
Diarrhea	Y or N	Constipation	Y or N

Please list any other medical conditions not listed above

_____

_____

Month and Year of your last stress test_____
It is your understanding this was normal? Y or N
Patient Name:_____Date_____

Previous Surgical Operations/Anesthetics

With respect to each and every operation which you have undergone, please provide the following information.

Operation	Date	Problems/Complications (if any)

Past Non-Surgical Hospitalizations

Please list all previous major non-surgical hospitalizations.

Problem	Date	Location/Hospital

Food Allergies

Have you ever had a reaction to any of the following:			If yes, please explain:
Milk/Dairy Products	Y	N	_____
Eggs	Y	N	_____

Shellfish/Iodine Y N _____
Patient Name:_____Date_____

Medication History

Please list current medications, including dosage and frequency.

Prescription Drugs

Name	Dose	Frequency

Over-the-Counter Medications/Vitamins

Medication Allergies

Are you allergic to any medications? □ Yes □ No

If so, please provide the following information concerning each and every medication to which you are allergic.

Name of Medication	Type of Reaction

Are you allergic to Latex? ☐ Yes ☐ No

Are you allergic to Iodine Dye? ☐ Yes ☐ No

Patient Name:_____Date:_____

Family History: Has anyone in your family had any of the following:

High blood pressure Y N _____

High cholesterol Y N_____

Heart disease Y N_____

Stroke Y N_____

Diabetes Y N_____

Cancer (list types)

_____

_____

_____

_____

Bleeding disorders Y N_____

Blood clots Y N_____

Additional Comments: _____

_____

_____

_____

Women:

Number of pregnancies:_____Number of live births:_____

Is it possible you could be pregnant?_____

Patient Name:_____Date_____

Alcohol, Tobacco and Drug Consumption

Alcohol:

How often do you drink alcohol?

□ Never □ Rarely (2 times per month or less) □ Occasionally (twice per week or less)
□ Daily (at least once per day)

If you indicated above that you drink "daily", please state:
How many times per day?_____
What type of alcoholic drink?_____

Have you ever participated in an alcohol or drug rehabilitation program?
□ Yes □ No

Tobacco:

Do you presently smoke tobacco? □ Yes □ No
If yes:
How many packs per day?_____

Have you ever smoked tobacco? □ Yes □ No
If yes:
How many packs per day?_____
For how many years?_____
When did you quit?_____

Do you presently use smokeless tobacco? □ Yes □ No
If yes: □ Snuff □ Chew

Have you ever used smokeless tobacco? □ Yes □ No
If yes:
When did you quit?_____

Drug Consumption:

Do you currently use illicit drugs? □ Yes □ No

If yes, what type of drugs do you currently use?_____

How often do you use illicit drugs?_____

Have you ever used illicit drugs? □ Yes □ No

When was the last time you used illicit drugs?_____

What type of illicit drugs?_____
How often?_____

Pharmacy Information

Pharmacy Name:_____

Address:_____

_____

Phone Number:_____Fax Number:_____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name:	
Address (if known)	
Telephone Number (if known)	
Hospital doctor is affiliated with:	

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name:	
Address (if known)	

Please list all other medical doctors with which you are currently being treated

PHYSICIAN NAME:	SPECIALTY:

My Beaumont Chart

Benefits to signing up for My Beaumont chart include,

1. Review your medications, allergies, and medical history.
2. Getting selected diagnostic test results by e-mail.
3. RECEIVING APPOINTMENT CONFIRMATION THROUGH E-MAIL

Interested in signing up for My Beaumont Chart Y N

_____

Print Name

If you respond YES to signing up for My Beaumont chart, a password and instructions will be given to you in the office.

Thank you,

Royal Oak Surgical Associates, P.C.