

Date _____, 20____

PATIENT INFORMATION

NAME _____ BIRTH DATE _____ AGE _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS (if different) _____

How Long at this Address _____ Marital Status _____ SS # _____

TELEPHONE # _____ CELL PHONE # _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE _____ HOW LONG EMPLOYED _____

NEAREST RELATIVE OR FAMILY MEMBER _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

May we share your medical information with this person? _____ Initials _____

REFERRING DOCTOR _____ PRIMARY CARE DOCTOR _____

SPOUSE or GUARDIAN INFORMATION

NAME _____ RELATIONSHIP TO PATIENT _____

SS # _____ BIRTH DATE _____

CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____

May we share your medical information with this person? _____ Initial _____

MEDICAL INSURANCE INFORMATION

INSURANCE CO _____ INSURED'S NAME _____

ID # _____ GROUP # _____ PHONE # _____

SECONDARY MEDICAL INSURANCE INFORMATION

INSURANCE CO _____ INSURED'S NAME _____

ID # _____ GROUP # _____ PHONE # _____



OREGON SURGICAL SPECIALISTS, P.C.
MEDICAL HISTORY QUESTIONNAIRE

DATE _____ FULL NAME _____

Sex: M F Birthdate _____ Age _____

Who referred you to our office? _____

What is the chief reason that you are consulting a surgeon? _____

Please circle any medical diseases for which you are now being treated now, have been treated in the past, or for which you have been admitted to the hospital:

- | | |
|---------------------|-----------------------------------|
| High blood pressure | Diabetes |
| Heart attack | Vascular disease |
| Angina | Hyperlipidemia / High cholesterol |
| Chest pain | Arthritis – Rheumatoid -- Osteo |
| Lung disease | Atrial Fibrillation |
| Other _____ | Aneurysm |

FEMALES: Age started menstruating? _____ # of pregnancies _____ # of deliveries _____
of c-sections _____ Date of last normal period _____ Hormone therapy _____

OPERATIONS:

<u>SURGERY NAME</u>	<u>DATE</u>	<u>HOSPITAL, CITY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS:

<u>MEDICATION NAME</u>	<u>TYPE OF RESPONSE</u>
_____	_____
_____	_____

Physician Review _____ Date _____

Have you ever had any anesthetic complications? _____

Have you ever had a life-threatening reaction to medication? _____

FAMILY HISTORY:

	<u>LIVING</u>	<u>AGE</u>	<u>CHIEF MEDICAL DISEASES</u>
Mother	Y N	_____	_____
Father	Y N	_____	_____
Brother	Y N	_____	_____
Brother	Y N	_____	_____
Sister	Y N	_____	_____
Sister	Y N	_____	_____

Circle diseases that tend to run in your family:

Diabetes

High blood pressure

Heart attacks

Strokes

Cancer

Bleeding disorders

Other _____

SOCIAL HISTORY:

Do you smoke? Y N Packs per day? _____ How long? _____ When did you stop? _____

Do you drink alcohol? Y N Type? _____ How much? _____

How often? _____

What type of work do you do, or have you done most of your life? _____

Please circle if you have the following current symptoms or problems:

HEENT

Trouble with your eyes

Seasonal allergies

CARDIOVASCULAR

Chest pain on exertion

Chest tightness on exertion

Angina

Chronic ankle swelling

Difficulty breathing when lying flat

Fainting spells

PULMONARY

Shortness of breath on exertion

Recurrent lung infections

Cough up blood

GI

Significant weight gain

Significant weight loss

Frequent nausea

Frequent vomiting

Frequent diarrhea

Frequent constipation

Change in bowel habits

Change in stool size

Black tarry stools

Blood in stools

GI, CONT.

Hemorrhoids

Hernias

Peptic ulcer disease

Vomiting blood

GU

Urinary incontinence

Burning w/ urination

MUSCULOSKELETAL

Chronic back pain

SKIN

Concerning skin lesions

NEUROLOGIC

Seizures

CVA (cerebrovascular accident)

TIA (stroke)

Loss of strength or sensation on one side

ENDOCRINOLOGY

Thyroid problems

Diabetes

HEMATOLOGY

Bleeding problems

Blood clots

Dietary History

Height: _____ Current Weight: _____ Desired Weight: _____

Weight at birth: _____ Lowest Weight in past 5 years _____

Weight at start of high school: _____ Highest Weight in past 5 years _____

Approximate age of first serious diet: _____

Please list any Food Allergies or Intolerances:

Please list your Vitamins, Minerals, Herbs, etc.

Please list diets and diet programs which you have tried:

Program	Date	Duration	MD Supervised	Maximum Loss
Weight Watchers				
Nutri-Systems				
Jenny-Craig				
Opti/Medi-Fast				
Fen/Phen				
Atkins				
Calorie Counting:				
Other				
Other:				
Other:				

Women: Estimate Weight Gained with Pregnancy

#1: Start _____ Delivery _____ #3: Start _____ Delivery _____

#2: Start _____ Delivery _____ #4: Start _____ Delivery _____

Regular Menses (if applicable)? _____

Food Preferences: Indicate which foods you prefer (which foods would most likely make you go off a diet.) Rank each selection from 1-Like Very Much to 4-Don't care.

- | | | |
|--------------------|-----------------------|------------------------|
| _____ Steaks/Chops | _____ Pizza | _____ Pasta |
| _____ Fried Foods | _____ Chips/Snacks | _____ French Fries |
| _____ Potatoes | _____ Breads | _____ Soda/Soft Drinks |
| _____ Candy | _____ Chocolate | _____ Cookies |
| _____ Cakes/Pies | _____ Salad Dressings | |

Weight Related Illnesses

Have you had or do you have any of the following illnesses or symptoms? Please fill in the blanks or circle where applicable.

Diabetes Year Diagnosed _____ Control with: Diet / Oral / Insulin
Blood sugars taken _____ times per day
Last reading _____ Gestational _____ Neuropathy _____

Asthma Year Diagnosed _____ # ER visits in last 2 years _____
Hospitalizations in last 2 years _____
Have you used steroids in the last year? _____

Sleep Apnea Syndrome Year Diagnosed _____ Sleep Study _____
CPAP Used? _____ cm Supplemental O2? _____
Morning headaches / Daytime drowsiness / Restless sleep / Snoring /
Frequent awakenings at night / Observed apnic episodes

High Blood Pressure Year Diagnosed _____ Treatment (Diet / Medication) _____

Heart Disease Year Diagnosed _____
Angina / M.I. / CABG / Abnormal EKG / Stress Test / Palpitations

High Cholesterol Year Diagnosed _____ High Triglycerides ? _____

Obesity/Hypoventilation Syndrome _____

Coughing or Choking at Night _____

Heartburn/Esophagitis/ Hiatus Hernia Year Diagnosed _____ Upper GI Series _____ Endoscopy _____
Medication taken _____ # Times per week
Prescription _____ Over the counter _____

Belching Acid or Sour fluid in Back of Throat _____

Gall Bladder Disease _____

Leakage of Urine with Laugh, Cough or Sneeze _____ Wears pad always / frequently

Pain in Hips/Knees/Ankles/Feet Seen by Chiropractor / Orthopedic Surgeon / Family Doctor
Takes pain / anti-inflammatory medication _____ # times per week

Low Back Pain/Sciatica Seen by Chiropractor / Orthopedic Surgeon / Family Doctor
Takes pain / anti-inflammatory medication _____ # times per week

Weight-Related Injuries and Trauma _____

Venous Stasis Disease/ Varicose Veins\Leg Ulcers; _____
Thyroid Disease _____ Medication _____

MEDICATION LIST

Allergic to _____

Patient Name _____ Date _____ DOB _____

Name of Med.	Strength	Dosage	Dr. Prescribing
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1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____

Over-The-Counter Medications- Include any taking regularly

Name	Strength	Dose Taking
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1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Medications Page 2

<i>Name</i>			<i>Date</i>
Name of Med	Strength	Dosage	Dr. Prescribing

14. _____

15. _____

16. _____

17. _____

18. _____

19. _____

20. _____

21. _____

22. _____

23. _____

24. _____

25. _____

26. _____

27. _____

28. _____

29. _____

30. _____

31. _____

32. _____

33. _____

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION
Oregon Surgical Specialists, PC

I authorize Oregon Surgical Specialists, PC to use and disclose the information of _____ for the purposes defined below:

Printed Patient Name

***Treatment** includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefits claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization. Also includes billing information shared with from the hospital or surgery center.

***Health Care** operations include the necessary administrative and business functions of our office.

You may review Oregon Surgical Specialists, PC detailed and extended "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this consent prior to signing this consent. This copy is posted in our waiting room on the "resource center" board.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change from time to time.

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that Oregon Surgical Specialists, PC has already used or disclosed the information in reliance on this consent.

Date

Signature of Patient

(or)

Date

Signature of Legal Representative