UR MEDICINE | THOMPSON HEALTH

Name:_____

DOB:_____ Age:_____

ADVANCED SURGICAL SERVICES NEW PATIENT FORM

PATIENT INFORMATION: **Appointment Date:_____**

Last Name: First Name: Preferred:

Address:_____

_____

Home Phone:_____ Mobile Phone:_____

Preferred Language:_____ Religion:_____

Primary Care Physician:_____ Phone:_____

Office Address:_____

Preferred Pharmacy:_____

INSURANCE INFORMATION:

Primary Coverage:

Insurance:_____ Subscriber ID_____

Subscriber Name:_____ Subscriber DOB:_____

Secondary Coverage:

Insurance:_____ Subscriber ID_____

Subscriber Name & DOB:_____ Secondary Coverage

REFERRAL INFORMATION:

Referring Physician:_____ Phone:_____

Address:_____ Fax:_____

Reason for Referral/Symptoms:_____

_____

How long has this been occurring? _____ Have you been treated for this before? _____

Previously Treating Physician:_____

Please circle the provider you are seeing today:

Dr. Peter **Dr. Wormer** **Dr. Talarico** **Jen Topor NP**

SOCIAL HISTORY:

Do you live: ☐Alone ☐with a Spouse or Partner ☐with Family ☐Other

Who do you rely on for support and help?_____

Do you smoke? ☐Currently ☐in the past ☐Never _____packs/day for _____years Date quit:_____

If you do smoke, are interested in quitting? ☐YES ☐NO

Other nicotine use ☐YES ☐NO

Exposure to second hand smoke? ☐YES ☐NO

Do you drink alcohol? ☐YES ☐NO ☐Beer ☐Wine ☐Liquor How many per week?_____

How many caffeinated beverages per day? _____ ☐Coffee ☐Tea ☐Sodas ☐Energy Supplements

Any recreational drug use? ☐YES ☐NO Type:_____

Do you exercise regularly? ☐YES ☐NO How many times per week?_____ Type:_____

Do you feel safe in your home? ☐YES ☐NO

How many hours of sleep do you get per night?_____ Do you wake feeling well rested? ☐YES ☐NO

SURGICAL/PROCEDURE HISTORY – Please check all that apply to you:

☐Appendix
☐Bladder Suspension
☐Colon/Rectal Surgery
☐Gallbladder
☐Eye Surgery
☐Dental Surgery
☐Kidney Surgery
☐Organ Transplant
☐Prostate Surgery
☐Thyroidectomy
☐Sinus Surgery
☐Tonsils/Adenoids
☐Tubal Ligation
☐Vasectomy
☐Heart Surgery
  ☐Bypass
  ☐Angioplasty
  ☐Stents
  ☐Pacemaker
☐Hysterectomy
  ☐Complete
  ☐Partial
☐Hernia
☐Blood Vessel Surgery
  ☐Arteries
  ☐Veins
☐Joint replacement or Orthopedic Surgery

SCREENING HISTORY – Please include date if known**:**

PAP: Date_____ Endoscopy: Date_____ Colonoscopy: Date_____
Mammogram: Date_____ Prostate Exam: Date_____

MEDICAL HISTORY – Please check all that apply to you:

- ☐ Bleeding Disorders/Blood clots/Anemia
- ☐ High blood pressure
- ☐ COPD/Asthma
- ☐ Diabetes
- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Seizures
- ☐ Kidney Disease/Stones
- ☐ Colitis
- ☐ Transplants
- ☐ Pacemaker/Defibrillator
- ☐ Cardiac Conditions
- ☐ Hepatitis
- ☐ Depression/Anxiety
- ☐ Capped/Loose Teeth
- ☐ Dentures
- ☐ Sleep Apnea/CPAP
- ☐ Barrett's Esophagus
- ☐ Thyroid Disease
- ☐ GERD/Acid Reflux
- ☐ Migraines/Headaches
- ☐ Heart Disease
- ☐ Gallstones
- ☐ Lung Disease
- ☐ Liver Disease/Hepatitis
- ☐ MRSA
- ☐ Hernia
- ☐ Cancer
- ☐ Recurrent Skin infections
- ☐ Recurrent UTI
- ☐ Arthritis
- ☐ Stroke
- ☐ TB
- ☐ Heart Valve Problems
- ☐ Mental Health Diagnosis
- ☐ Irritable Bowel
- ☐ High Cholesterol
- ☐ Artery/Vein Problems
- ☐ Autoimmune Disease
- ☐ Esophagitis/Ulcers
- ☐ Chronic Pain
- ☐ Gout
- ☐ Glaucoma
- ☐ Fractures/Osteoporosis
- ☐ Cataracts
- ☐ HIV/STI's

Other Diseases not listed above:_____

_____

Previous reaction to anesthesia: (explain)_____

_____

Family History:

Family Member	Age(s)	Living	Cause of Death
Father			
Mother			
Brother(s) #			
Sister(s) #			

Diseases in the family: (Please check all that apply)

- ☐ Arthritis
- ☐ Addiction
- ☐ Bleeding Problems
- ☐ Depression/Anxiety
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Cancer
  - ☐ Breast
  - ☐ Colon
  - ☐ Prostate
  - ☐ Other
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease

Please list all medications that you are currently taking (include vitamins and herbal supplements, aspirin, or NSAID's):

Name of Medication	Dose Taken	How often	Name of Medication	Dose Taken	How often

Please List all allergies, including latex. Please include the reaction:_____

_____

_____

Do you have to take any antibiotics prior to any procedures or going to the dentist? YES NO

If YES, what is the reason? _____

_____

Patient Signature Date

Health History Reviewed By:_____ Date:_____