

Patient History

Date:

Name:	Age:	M or F
Date of Birth:	Marital Status: M S D W	
Primary Physician:	Daytime phone #:	

Reason for visit (Describe all pertinent symptoms):

Past Medical History (List all medical problems):

Previous Surgeries:

Anesthesia complications? (You or a family member)

Current Medications (List dose, frequency and bring medications with you to appointment):

Allergies to medications:

Occupation:	Living Will?:
Tobacco use (Type, amount, for how long, when quit):	
Alcohol use (Type, amount, for how long, when quit):	
Illicit drug use (Type, method, when):	

Family History (List illnesses, current age or age at death and cause of death for each):

Mother:

Father:

Sister:

Brother:

Other:

Any illnesses which are prevalent in your family:

SYSTEM REVIEW

General	Yes	No	Comment
Weight Gain/Loss	()	()	_____
Fevers	()	()	_____
Night Sweats	()	()	_____
Appetite	()	()	_____
Eyes			
Visual Change	()	()	_____
Eye Surgery	()	()	_____
Glaucoma	()	()	_____
ENT & Mouth			
Hearing problems	()	()	_____
Frequent nose bleeds	()	()	_____
sinus Problems	()	()	_____
Sores in mouth/throat	()	()	_____
Difficulty swallowing	()	()	_____
Lump sensation in throat	()	()	_____
Hoarseness	()	()	_____
Cardiovascular			
Heart attack	()	()	_____
High blood pressure	()	()	_____
Chest pain (angina)	()	()	_____
Heart surgery	()	()	_____
Congestive heart failure	()	()	_____
Shortness of breath	()	()	_____
Circulatory problems	()	()	_____
Leg cramps	()	()	_____
Foot pain/sores	()	()	_____
Surgery on arteries	()	()	_____
Phlebitis/blood clots	()	()	_____
Leg ulcers	()	()	_____
Respiratory			
Emphysema	()	()	_____
Chronic Cough	()	()	_____
Cough blood	()	()	_____
Lung surgery	()	()	_____
Pneumonia	()	()	_____
Asthma/Bronchitis	()	()	_____
Blood clots in lung	()	()	_____
Sleep apnea	()	()	_____
Gastrointestinal			
Abdominal pain	()	()	_____
Abdominal surgery	()	()	_____
Bloody vomiting	()	()	_____
History of ulcers	()	()	_____
Bowel changes	()	()	_____
Bloody/black stool	()	()	_____
Heartburn	()	()	_____
Jaundice	()	()	_____

Women Only			
Last menstrual period	Yes	No	Comment
Birth control	()	()	_____
Menopause	()	()	_____
Pap smear/pelvic exam	()	()	_____
Pregnant now	()	()	_____
No. of Pregnancies _____ Births _____ Miscarriages _____			

Musculoskeletal			
Hernia	()	()	_____
Arthritis	()	()	_____
Rheumatoid disease	()	()	_____
Muscle wasting/weakness	()	()	_____
Osteoporosis	()	()	_____
Orthopedic surgery	()	()	_____
Skin/Breast			
Skin cancer	()	()	_____
Non-healing sores	()	()	_____
Breast lump/biopsy	()	()	_____
Breast pain	()	()	_____
Nipple discharge	()	()	_____
Dimpling of breast skin	()	()	_____
Breast cancer	()	()	_____
Mammogram (when)	()	()	_____
Neurological			
Stroke	()	()	_____
Seizure/Epilepsy	()	()	_____
Severe head injury	()	()	_____
Numbness/tingling	()	()	_____
Psychiatric			
Depression	()	()	_____
Schizophrenia	()	()	_____
Other Psychiatric	()	()	_____
Endocrine			
Diabetes/metabolic disease	()	()	_____
Thyroid/Glandular disease	()	()	_____
High cholesterol	()	()	_____
Hematologic			
Bleeding disorder	()	()	_____
Take aspirin	()	()	_____
Blood transfusion	()	()	_____
Blood diseases	()	()	_____
Lumps	()	()	_____
Neck	()	()	_____
Armpits	()	()	_____
Groin	()	()	_____
Allergic/Immunologic			
Exposure to communicable diseases			
AIDS/HIV	()	()	_____
Hepatitis	()	()	_____
Tetanus vaccine (when)	()	()	_____
Prednisone/steroid use	()	()	_____
Genitourinary			
Kidney disease/Stones	()	()	_____
Painful/Bloody urination	()	()	_____
Difficult urination	()	()	_____

Dr. Initials/Date: _____



Advanced
Surgery of Idaho

expert care from a compassionate team

Today's date: _____ Who may we thank for referring you: _____

Patient's name: _____

Last

First

Middle

Date of Birth: _____ Sex: Male Female Social Security #: _____

Residence Address: _____

Street

City

State

Zip

Mailing Address (if different): _____

Street

City

State

Zip

Home Phone: _____ Cell: _____ Email: _____

Marital Status: Single Married Widowed Other

Student Status: FT PT Not a Student

Patient Employer: _____ Full Time Part Time

Occupation : _____ Work Phone: _____ Is heavy lifting required? Yes No

Contact: _____

Name

Title

Phone

Ext.

Spouse Name: _____

Date of Birth: _____ Social Security #: _____

Spouse Employer: _____ Work Phone: _____

Patient Primary Insurance Carrier: _____

Subscriber Name: _____ Policy #: _____

Group #: _____ Group Name: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Patient Secondary Insurance Carrier: _____

Subscriber Name: _____ Policy #: _____

Group #: _____ Group Name: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Please give us the name and phone number of a friend or family member **outside of the home** who can take a message for you if you are unavailable:

Name: _____ Phone #: _____

Relationship: _____

In case of an EMERGENCY please contact:

Name: _____ Phone #: _____

Relationship: _____

Patient Signature: _____ Date: _____

Medicare / Insurance Lifetime Assignment of Benefits

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Advanced Surgery of Idaho for any services furnished to me by its providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it.

I understand and agree that any unpaid balance is my financial responsibility. If I fail to pay for services for which I am responsible, after such default and upon referral to a billing service or collection agency by Advanced Surgery of Idaho, I will be responsible for all costs of collecting monies owed, including court costs, and collection agency fees.

My signature below reflects my acceptance of, and consent to, the information disclosed above.

** SIGNATURE: _____

DATE: _____

WITNESS: _____

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION (PHI) FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

- As part of my health care, Advanced Surgery of Idaho originates and maintains health records describing my health history, symptoms, examinations, diagnoses and treatment.
- The use and disclosure of my protected health information by Advanced Surgery of Idaho is necessary in order to provide me medical care, to obtain payment for my treatment and to carry out the practice's health care operations.
- I have the option to receive a copy of Advanced Surgery of Idaho's Notice of Privacy Practices which provide a more complete description of the use and disclosure of my health information and that I have the right to review that Notice prior to signing this consent. I also understand that Advanced Surgery of Idaho reserves the right to change the Notice and its privacy practices at any time and that if I request, Advanced Surgery of Idaho will mail me a copy of any revised Notice prior to its implementation.

I have read and understand the foregoing notice:

** SIGNATURE: _____

DATE: _____

WITNESS: _____