ST. LOUIS SURGICAL CONSULTANTS, PC.

DATE: _______________

PATIENT NAME: ____ DOB: ____________________________

PRIMARY PHYSICIAN: ______________________________ REFERRING PHYSICIAN (IF DIFFERENT): ________________________

OTHER PHYSICIANS: ____

CHIEF COMPLAINT: ____
(What problem brings you to our office today; e.g. abdominal pain, leg pain, surgical post-op)

HISTORY OF PRESENT ILLNESS/CHIEF COMPLAINT: *Please describe the signs/symptoms that you have, when they started, how they've changed*

Location: *Where is the problem?* ____

Severity: *circle* **mild / moderate / severe** ____

Duration: *How long does/did it last?* ____

Associated Signs/Symptoms: ____

When did this start? ____

Did you have lab work or x-rays? **yes / no** Please explain: ___________________________________

CT Ultrasound MRI X-ray Blood Work Cultures Barium enema Lower GI study Colonoscopy

PAST MEDICAL HISTORY: *Please check all that apply*

Diabetes – *age of onset* _______
- Insulin Dependent Neuropathy present

High Blood Pressure

Heart Disease:
- A. fib CHF Stent/Bypass/Pacemaker
- Heart Attack: *Date* ________

Stroke: *Date* ________ TIA: *Date* ________

History of:
- Migraines Seizures

High Cholesterol

Cancer *Please specify* __________________

Bleeding/Bruising Tendency
- taking blood thinners
  - *aspirin, Plavix, Coumadin, Pradaxa*

Thyroid Disease

Kidney Disease *Please specify* _______________
- Dialysis *Please specify days*: M T W T F S Su

Organ Transplant *Please specify* _______________

Parkinson's Disease

Asthma COPD Emphysema

Sleep Apnea *w/ CPAP*

Arthritis

Autoimmune Disorder – *Lupus, RA*
- *Please specify* __________________

Staph Infection / MRSA Infection *nasal swabs?*
- *Location:* __________________
- *Dates:* ____________________

Other Infections *e.g. abscess/cellulitis*
- *Please specify* __________________

History of:
- Leg ulcers GI ulcers

Acid Reflux / Heartburn

Crohn's Disease IBS

Ulcerative Colitis Diverticulitis

Hepatitis – A B C

HIV/AIDS

Prior Blood Transfusion Anemia

Raynaud's Disease

PAST SURGICAL HISTORY:

*(e.g. Hernia Repair / Cataracts / Coronary Bypass / Stent Placement (**heart, leg**) / Appendectomy / C-section)*

Date:	Procedure:
___________	____
___________	____
___________	____
___________	____
___________	____
___________	____
___________	____

Patient Name: ________________________________ *Date of Birth:* _____ / _____ / ______

HOSPITALIZATION HISTORY: *NOT RELATED TO SURGERIES*

Date:	Diagnosis/Reason for Stay:
__________	____
__________	____

FAMILY MEDICAL HISTORY:

(DM=diabetes, HBP= High Blood Pressure, HD=heart disease, CA=cancer)

	Deceased	**Unknown**	**DM**	**HBP**	**HD**	**Stroke**	**CA: *Type***	**Other:**
Father							________	____________________
Mother							________	____________________
Siblings							________	____________________
Children							________	____________________

ADDITIONAL FAMILY HISTORY:

	Family Member Involved		*Family Member Involved*
Colon/rectal cancer	____________________	Crohn's disease	____________________
Colon/rectal polyps	____________________	**Breast cancer**	____________________
Ulcerative colitis	____________________		

SOCIAL HISTORY:

Marital Status: Single Married Widowed Divorced Separated Life Partner

Alcohol Use: Never Rarely Moderate Heavy

Recreational Drug Use: Never Not Currently Currently *Please specify* ____________________

Tobacco Use*: Never Former: *Quit Date:* __________
Current: *# of Cigarettes/day* _______ Smokeless Tobacco

CURRENT REVIEW OF SYSTEMS: *Please check all that you are **CURRENTLY** experiencing today.*

Blank responses will be considered a "no" response

CONSTITUTIONAL

Weight Change ↑ ↓	No	Yes
Loss of appetite	No	Yes
Fever	No	Yes
Fatigue	No	Yes

DERMATOLOGY

Rash _________	No	Yes
Lumps ________	No	Yes
Keloid Formation	No	Yes

OPHTHALMOLOGY

Glaucoma	No	Yes
Glasses/Contacts	No	Yes
Disease or Injury– *B R L*	No	Yes
Blurred Vision – *B R L*	No	Yes
Loss of Vision – *B R L*	No	Yes

EAR, NOSE, MOUTH, THROAT

Nose Bleeds	No	Yes
Hearing Loss	No	Yes
Use of hearing aids	No	Yes
Change in Voice	No	Yes
Sore throat/swollen glands	No	Yes
Ringing in ears – *B R L*	No	Yes

CARDIOVASCULAR

Foot/ankle swelling	No	Yes
Chest Pain *(currently)*	No	Yes
Dizziness	No	Yes
Edema	No	Yes

RESPIRATORY

Shortness of breath	No	Yes
Bronchitis	No	Yes
Emphysema	No	Yes
Asthma/wheezing	No	Yes

GASTROINTESTINAL

Nausea	No	Yes
Vomiting	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Painful urination	No	Yes
Blood in urine	No	Yes
Incontinence	No	Yes
Kidney Stones	No	Yes

MUSCULOSKELETAL

Muscle pain/cramps	No	Yes
Muscle weakness	No	Yes

Patient Name: ___________________________________ *Date of Birth:* _____ / _____ / ______

Joint pains No Yes
Joint swelling No Yes

NEUROLOGY

Headache No Yes
Tension / Migraine
Tingling/Numbness No Yes
Location: ___________
Insomnia No Yes
Gait Abnormality No Yes
Wheelchair / Walker

PSYCHOLOGY

Memory loss/confusion No Yes
Depression No Yes
Anxiety No Yes

ENDOCRINOLOGY

Hormone Replacement No Yes
Estrogen / Testosterone
Cold Intolerance No Yes
Heat Intolerance No Yes

HEMATOLOGY

Phlebitis No Yes
Varicose Veins - *R L* No Yes

BREAST

Pain - *R L* No Yes
Lump - *R L* No Yes
Nipple Discharge - *R L* No Yes

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*COLORECTAL PATIENTS ONLY:

Anal/Rectal bleeding No Yes (*if yes*) Bright red ____ Dark Red ____ with Pain ____ without Pain ____
Regular bowel movements No Yes # of BMs per day ____ Formed ____ Loose ____
Anal/Rectal Pain No Yes
Anal/Rectal Itching No Yes
Protrusion of rectal tissue to the outside with bowel movements? No Yes
Abdominal pain No Yes
Difficulty controlling bowel movements? No Yes

Last Colonoscopy – Date: ____ / _____ / ______ Performed By: Dr. ______________________________

Performed At: _______________________________________ (*St. Luke's Hosp*)

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*PATIENTS 65 YEARS OR OLDER ONLY:

FALL RISK ASSESSMENT: *65 years or older*

In the past year have you fallen… **No**

Without injury 1 time 2 or more times
With injury 1 time 2 or more times

PAST IMMUNIZATION HISTORY:

Date Last Received

Pneumonia Vaccine _______________ *65 years or older*
Influenza Vaccine _______________
(Flu Shot)

St Louis SURGICAL CONSULTANTS

Appointment Date: _____ / _____ / _______

Name: ____ Date of Birth: _____ / _____ / _______

PATIENT MEDICATION SHEET

Please List Current Prescription & Over-The-Counter Medications (including vitamins and minerals):

Don't forget to include your ASPIRIN!

Medication Name	Strength	Formulation	Take	Frequency
Example: Vitamin XX	MG, %, mcg, etc.	Tablet, Capsule, Inhaler, Cream, etc.	½ Tablet, 1 Puff 2 Sprays, etc.	Once at Day, Every 6 Hours, At Bedtime, As Needed, Every Other Day, etc.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Medication Allergies

☐ NO KNOWN DRUG ALLERGIES

Medication Name	Reaction
Ex: XXXXXXXXXXXX	Hives, Nausea, Shortness of Breath, etc.
1.	
2.	
3.	
4.	
5.	
6.	
7.	

ST. LOUIS SURGICAL CONSULTANTS – DEMOGRAPHIC FORM

For Office Use Only
Entry Initials ________

Which Physician are you seeing today? Circle One

Dr. Niesen Dr. Cronin Dr. Mason Dr. Fahrner Dr. Dunn Dr. Ha Nurse Practitioner

Other ___________________________________

Patient Name (Last) __________________________________ (First) __________________________ (MI) ________

Mailing Street Address ____

City ____ **State** _______________ **Zip** _______________

Date of Birth _____ / _____ / _______ **Sex** ______ **Social Security No**. ________ - ______ - __________

Please only provide numbers where a BRIEF message may be left.

Home (_____) _____ - _________ May we leave a detailed message at this number? **No**

Cell (_____) _____ - _________ May we leave a detailed message at this number? **No**

May we text (SMS) appointment reminders to your cell number? **Yes** **No**

Primary Care Physician ______________________________ **Referring Physician** _______________________

Email Address ____

Your email address will **not** be shared with anyone outside of our medical practice. We will only use it to correspond with you regarding such things as appointment reminders and to give you access to our practice's patient portal.

Race: White Black Hispanic Asian Other _____________________

Ethnicity: Hispanic Non-Hispanic Refuse to Report

Primary Language: English Spanish Other _____________________________

Local Pharmacy Information (*Non-Mail Order*)

Pharmacy Name ____ Phone (_____) _____ - _________

Pharmacy Location (Cross-Streets) ____

Emergency Contact Information

Name _________________________________ Relationship ______________ Phone (_____) _____ - _________

Name _________________________________ Relationship ______________ Phone (_____) _____ - _________

HIPAA Privacy Requirements

Our practice defines 'personal health information' as any information that is protected under the HIPAA Privacy Rule. It includes, but is not limited to, all appointment information, lab/test results, nursing questions, surgery scheduling, etc. We will NOT disclose ANY of your personal health information to anyone that you specify below.

Is there anyone *(family member, friend)* with whom we should NOT share your health information with?

Name _________________________________ Relationship ________________ Phone (_____) _____ - __________

Name _________________________________ Relationship ________________ Phone (_____) _____ - __________

Patient Name: ___________________________________ *Date of Birth:* _____ / _____ / ______

Guarantor Information

Primary Insurance ____

Primary Insurance Holder ____________________________________ Relationship to Patient ____________________

Insured's Address ______________________________________ City _______________ State ________ Zip _________

Insured's Date of Birth ____________________ Social Security No. ________________ Phone ____________________

Employer____ Employer's Phone______________________________

Secondary Insurance ____ ***Not applicable***

Secondary Insurance Holder __________________________________ Relationship to Patient ____________________

Insured's Address ______________________________________ City _______________ State ________ Zip _________

Insured's Date of Birth ____________________ Social Security No. ________________ Phone ____________________

Employer____ Employer's Phone______________________________

Marital Status Single Married Divorced Widowed Legally Separated

Spouse Info: Name____ Date of Birth____/______/_______

Primary Phone (_____) _____ - _________

Responsible Party Information (*if other than patient*) – **Must be completed for all patients under the age of 18**

Name of Person Responsible for Payment ______________________________________ Relationship _______________

Address ____ City ______________________ State ________ Zip _________

Date of Birth _____ / _____ / _______ Social Security No. _____ - _____ - ________ Phone (_____) _____ - _________

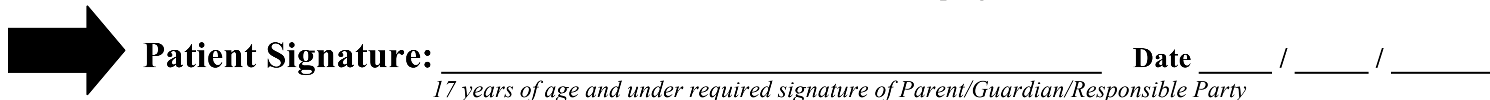
Medicare Patients Only – *All Fields Must Be Completed!*

Patients Age________ Is the patient currently employed **Y** or **N**

Is the Patient Disabled **Y** or **N** Is the patient currently retired? **Y** or **N**

Is the patient currently married? **Y** or **N** *If **yes** is the patient's spouse currently employed?* **Y** or **N**

By signing below, I am acknowledging that I am either the patient or the patient's personal representative. I hereby authorize the release, of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by St. Louis Surgical Consultants. *Notice of Privacy Practice*: My signature below also indicates that I have reviewed the "Notice of Privacy Practices" for St. Louis Surgical Consultants and understand that I may contact the person named in the Notice if I have questions about the content of the notice. *ePrescribing*: By signing this consent form I am also agreeing that SLSC can request and use my prescription medication history from other healthcare Providers and/or third party pharmacy benefit payers for treatment purposes and provide informed consent to be enrolled in the ePrescribe program.



Patient Signature: ____ **Date** _____ / _____ / _______

17 years of age and under required signature of Parent/Guardian/Responsible Party