Prevent Med: Smoking/BMI: _____ | *ABOVE LINE - For Office Use Only* | *Ht: _____* *BP: _____* | *Intake*

Entry: _____ | *BELOW LINE – Patient to Complete* | *Wt: _____* *P: _____*

ST. LOUIS SURGICAL CONSULTANTS, PC.

APPOINTMENT DATE: ____ / ____ / _____

PATIENT NAME:_____ DOB: ____ / ____ / _____ Age: _____

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
- ☐ Acid Reflux / Heartburn
- ☐ 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 ulcer
  - ☐ Colon/rectal polyps
- ☐ Crohn's Disease ☐ IBS
- ☐ Ulcerative Colitis ☐ Diverticulitis
- ☐ Hepatitis – A B C
- ☐ HIV/AIDS
- ☐ Prior Blood Transfusion ☐ Anemia
- ☐ Raynaud's Disease

☐ **Other** _____

PAST SURGICAL HISTORY:

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

Date:	Procedure:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Website

Patient Name: _____ ***DOB*** ____ / ____ / _____

HOSPITALIZATION HISTORY: *NOT RELATED TO SURGERIES*

Date:	Diagnosis/Reason for Stay:
_____	_____
_____	_____
_____	_____

FAMILY MEDICAL HISTORY:

☐ **I am Adopted**

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

	Deceased	**Unknown**	**DM**	**HBP**	**HD**	**Stroke**	**CA:** ***Type***	*Alive & Healthy*	**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:

Occupation: _____ ☐ ***Lifts more than 20 lbs.***

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 ☐ E-Cigarettes

Start Date (YEAR): _____

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

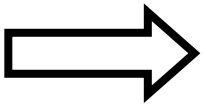
RESPIRATORY

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

Please complete next page



Patient Name: _____ ***DOB*** ____ / ____ / _____

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
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

Blank responses will be considered a "no" response

---

*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*)

---

*PATIENTS 65 YEARS OR OLDER ONLY

PAST IMMUNIZATION HISTORY:

	Date Received	*Best Guess*
Pneumonia Vaccine	____ / ____ / _____	

PRIMARY CARE PROVIDER FOLLOW UP:

Have you visited your **Primary Care Provider** this year? ☐ Yes ☐ No
Are you planning on visiting your **Primary Care Provider** this year? ☐ Yes ☐ No

*We STRONGLY encourage all patients to see their PCP **every year***

Patient Name: _____ ***DOB*** ____ / ____ / _____

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.				

**To list additional medications please ask for 2nd sheet*

Medication Allergies

☐ **NO KNOWN DRUG ALLERGIES**

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

For Office Use Only

Entry Initials _____

PATIENT DEMOGRAPHIC FORM

Whom are you seeing today? ***Circle One***

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

Other _____

Patient Name (Last) _____ (First) _____ (MI) _____

Mailing Street Address _____

City _____ **State** _____ **Zip** _____

Currently Resides at:

- ☐ Home
- ☐ Assisted Living Facility / Skilled Nursing Facility / Rehab *(☐ planning to return home)*

Facility Name _____ *Phone Number* _____ - _____-_____

- ☐ Other _____

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? **Yes** *No*

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

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

Primary Care Physician _____ **Referring Physician** _____

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 *Those listed may be contacted if our office is unable to reach the patient by phone*

Name _____ Relationship _____ Phone (_____) _____ - _____

Name _____ Relationship _____ Phone (_____) _____ - _____

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.

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. Be aware that health information will be shared with other health providers, insurance and billing companies, as well as anyone we feel is involved in your care.

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

Name _____ Relationship _____ Phone (_____) _____ - _____

Name _____ Relationship _____ Phone (_____) _____ - _____

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_____

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 (_____) _____ - _____

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

Printed Name: _____ DOB: ____ / ____ / _____

PRIVACY PRACTICES, PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, EPRESCRIBING, & FINANCIAL POLICY

Thank you for choosing St. Louis Surgical Consultants as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our policies.

- Please be sure to provide us with your most current insurance information.
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your Primary Care Physician listed on your Insurance Card before you are seen by another healthcare provider.
- Co-Payments are due at time of service.
- You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.
- You have the right to request a copy of the St. Louis Surgical Consultants Notice of Privacy Policy.
- By signing below, you acknowledge that you have reviewed the "Notice of Privacy Practices" for St. Louis Surgical Consultants and understand that you may contact the person named in the Notice if you have questions about the content of the notice.
- By signing below, you acknowledging that you are either the patient or the patient's personal representative and 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.
- By signing this consent form you are agreeing that SLSC can request and use your 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.

By signing below you acknowledge that you have read the information above and fully understand its terms.

Appointment Date: **____ / ____ / _____**

PRINTED Patient Name:_____

Patient/Responsible Party SIGNATURE_____ ____ / ____ / _____