*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* ___________
☐ High Cholesterol
☐ Stroke: *Date* ________ ☐ TIA: *Date* ________
☐ Bleeding/Bruising Tendency
☐ **Taking blood thinners**
  *- aspirin, Plavix, Coumadin, Pradaxa, Elliquis*
☐ Thyroid Disease *HYPO / HYPER*
☐ Kidney Disease *Please specify* _______________
  ☐ Dialysis *Please specify days*: M T W T F S Su
  *Dialysis Facility*: ___________________________
☐ Organ Transplant *Please specify* _______________
☐ Asthma ☐ COPD ☐ Emphysema
☐ Sleep Apnea ☐ *w/ CPAP*
☐ Staph Infection / MRSA Infection *nasal swabs?*
  *Location:* ___________________
  *Dates:* _____________________
☐ Other Infections *e.g. abscess/cellulitis*
  *Please specify* __________________
☐ Cancer *Please specify* __________________

☐ Malnutrition
☐ Obesity / Morbid Obesity *(BMI >30)*
☐ History of:
  ☐ Leg ulcers ☐ GI ulcer
  ☐ Colon/rectal polyps
☐ Acid Reflux / Heartburn
☐ Crohn's Disease ☐ IBS
☐ Ulcerative Colitis ☐ Diverticulitis
☐ Hepatitis – A B C
☐ HIV/AIDS
☐ Prior Blood Transfusion ☐ Anemia
☐ Raynaud's Disease
☐ Arthritis ☐ Osteoarthritis
☐ Autoimmune Disorder – *Lupus, RA*
  *Please specify* ___________________
☐ **Taking Immune Suppressants**
  *- Steroids, methotrexate, Imuran, Cyclosporine, DMARDs*
☐ Parkinson's Disease
☐ History of:
  ☐ Migraines ☐ Seizures
☐ Dementia

☐ **Other** ________________________________

## PAST SURGICAL HISTORY:

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

| Date: | Procedure: |
|---|---|
| ___________ | ________________________________ |
| ___________ | ________________________________ |
| ___________ | ________________________________ |

***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 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ________ | ☐ | ___________________________ |
| Sibling*s* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ________ | ☐ | ___________________________ |
| Child*ren* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ________ | ☐ | ___________________________ |

## 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 <u>more</u> 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

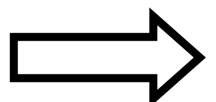
**Start Date (YEAR):** ______

## 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<br>*Tension / Migraine* | ☐ No | ☐ Yes |
| Tingling/Numbness<br>Location: ___________ | ☐ No | ☐ Yes |
| Insomnia | ☐ No | ☐ Yes |
| Gait Abnormality<br>*Wheelchair / Walker* | ☐ No | ☐ Yes |

**PSYCHOLOGY**

| | | |
|---|---|---|
| Memory loss/confusion | ☐ No | ☐ Yes |
| Depression | ☐ No | ☐ Yes |
| Anxiety | ☐ No | ☐ Yes |

**ENDOCRINOLOGY**

| | | |
|---|---|---|
| Hormone Replacement<br>*Estrogen / Testosterone* | ☐ No | ☐ Yes |
| 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***

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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

## 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*

☐ **Taking blood thinners**
*- aspirin, Plavix, Coumadin, Pradaxa, Elliquis, warfarin*

☐ **Taking Immune Suppressants**
*- Steroids, methotrexate, Imuran, Cyclosporine, DMARDs*

# Medication Allergies

☐ **NO KNOWN DRUG ALLERGIES**

| Medication Name | Reaction |
|---|---|
| **Ex:** XXXXXXXXXXXX | Hives, Nausea, Shortness of Breath, etc. |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

☐ **Latex Sensitivity / Allergy**

For Office Use Only

Entry Initials ________

# PATIENT DEMOGRAPHIC FORM

**Whom are you seeing today?**

Dr. ____________________________ 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____________________

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## 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. *Photography*: By signing this consent I am also agreeing to photography through a secure application to be uploaded in my EMR account. *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*