American Advanced Surgery
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PATIENT INFORMATION

Name (Last, First, MI):		Date:
Street Address: City, State, Zip:		Phone:
Social Security Number:	Birth date:	Age:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Sex: ☐ Male ☐ Female
Referring Doctor: Address & Phone Number:		
Primary Care Doctor: Address & Phone Number:		
Spouse Name:		Occupation:
Spouse/Nearest Relative: Address & Phone Number:		

In Case of Emergency Contact: Address & Phone Number:	
Dialysis Center (if applicable) Name:	Phone Number:

Guarantee of Accurate Information*: I guarantee that this information is correct and understand that I am responsible for financial loss due to inaccurate or incomplete information provided by me.*

Authorization to Release Information: *I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment.*

Authorization to Pay: *I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services.*

I understand that I am financially responsible for the charges not covered by my insurance.

Patient Signature: _____ *Date:* _____

Family History

Fill in information about your immediate family

Relation	*Age*	*State of Health*	*Age at Death*	*Cause of Death*	*Check if your blood relatives any of the following:*	
					Disease	*Relationship to you*
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

Hospitalizations

Year	*Hospital*	*Reason for Hospitalization and Outcome*

Pregnancies

Year of Birth	*Sex of Birth*	*Complications if any*

Health Habits

Check which you use and note how much you use.

☐	***Caffeine***	
☐	***Tobacco***	
☐	***Street Drugs***	
☐	***Other***	

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: _____

Illness/Injuries

Serious Illness/Injury	*Date*	*Outcome*

Occupational

Check if your work exposes you to:

☐	***Stress***	☐	***Hazardous Substances***
☐	***Heavy Lifting***	☐	***Other***

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative ***Date***

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative ***Relationship to Patient***

_____ _____

Reviewed By ***Date***

Confidential Health History

Patient Name_____ Today's Date_____ (mm/dd/yy)
Age_____ Birth date_____ Date of last physical examination_____ (mm/dd/yy)
What is the reason for your visit?_____.

Symptoms

*check symptoms you currently have or have had in the past year.

General
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of Sleep
☐ Loss of Weight
☐ Nervousness
☐ Numbness
☐ Sweats

Gastrointestinal
☐ Appetite Poor
☐ Bloating
☐ Bowel Changes
☐ Constipation
☐ Diarrhea
☐ Excessive Hunger
☐ Excessive Thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal Bleeding
☐ Stomach Pain
☐ Vomiting
☐ Vomiting Blood

Eye, Ear, Nose, Throat
☐ Bleeding Gums
☐ Blurred Vision
☐ Crossed Eyes
☐ Difficulty Swallowing
☐ Double Vision
☐ Earache
☐ Ear Discharge
☐ Hay Fever
☐ Hoarseness
☐ Loss of Hearing
☐ Nosebleeds
☐ Persistent Cough
☐ Ringing in Ears
☐ Sinus Problems
☐ Vision- Flashes
☐ Vision- Halos

MEN ONLY
☐ Breast Lump
☐ Erection Difficulties
☐ Lump in Testicles
☐ Penis Discharge
☐ Sore on penis
☐ Other

WOMEN ONLY
☐ Abnormal Pap Smear
☐ Bleeding between Periods
☐ Breast Lump
☐ Extreme Menstrual Pain
☐ Hot Flashes
☐ Nipple Discharge
☐ Painful Intercourse
☐ Vaginal Discharge
☐ Other

Muscle/Joint/Bone Pain, weakness, numbness in:			
☐	Arms	☐	Hips
☐	Back	☐	Legs
☐	Feet	☐	Neck
☐	Hands	☐	Shoulders

Cardiovascular
☐ Chest Pain
☐ High Blood Pressure
☐ Irregular Heart Beat
☐ Low Blood Pressure
☐ Poor Circulation
☐ Rapid Heart Beat
☐ Swelling of Ankles
☐ Varicose Veins

Skin
☐ Bruise Easily
☐ Hives
☐ Itching
☐ Change in Moles
☐ Rash
☐ Scars
☐ Sore that won't heal

Genito-Urinary
☐ Blood in Urine
☐ Frequent Urination
☐ Lack of Bladder Control
☐ Painful Urination

Date of Last Menstrual Period?_____.
Date of Last Pap Smear?_____.
Have you ever had a mammogram? ____.
Are you Pregnant?_____.
Number of Children? _____.

Conditions

*check symptoms you currently have or have had in the past year.

☐ AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal Disease

Current Medications_____Allergies_____.

Pharmacy Name_____Pharmacy Telephone _____.