EVERGREEN SURGICAL MEDICAL HISTORY FORM

Thank you for providing us with the following information:

DATE

Name:	DOB:	Age:
Which physician are you seeing today? ☐ Immerman ☐ Wogahn ☐ Daniels		
Who is your family physician?	*Office Staff Only:*	
What problem or concern brings you to see us?	WT	HT
	BP	Pulse
		Resp

Have you ever had...
any problems with anesthesia before? ☐ No ☐ Yes
If yes, please explain:

unusual Bleeding during surgery? ☐ No ☐ Yes
If yes, please explain:

Are you currently on "blood thinners" or anti-coagulant medication, including aspirin? ☐ No ☐ Yes
If yes, which medication:

☐ Check here if you are a Jehovah's Witness

Have you ever had surgery before?

✔	Operation	~ Year Done	✔	Operation	~ Year Done
	Appendectomy			Orthopedic Surgery	
	Gallbladder Removal			Caesarean Section	
	Heart Surgery			Hysterectomy	
	Prostate Surgery			Back Surgery	
	Hernia Repair			Tonsillectomy	
	Breast Surgery			Other:	
	Pacemaker/Defibrillator (note date/cardiologist):				

CURRENT MEDICATIONS

DRUG NAME (include non-prescription or "over the counter" medications you take with any regularity)	DOSE	HOW OFTEN TAKEN	REASON FOR MEDICINE

What is your preferred pharmacy? (List name and location)

Medication Allergies/Reactions:

FAMILY HISTORY: Are there any medical problems that run in your family? ☐ no ☐ yes, please explain:

List any diseases which caused significant illness or death of a parent or sibling in your family: (if not listed above)

For Female Patients Only: Have any women on your mother's side of your family had breast cancer? ☐ no ☐ yes, list relationship to you:

OVER ▶

Do you wear:	☐ glasses/contacts to correct vision	☐ wear hearing device
	Dentures: ☐ upper ☐ lower ☐ partial	☐ prosthesis: (describe)

Do you currently have any of the following medical problems, or have you experienced any of these problems?

☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure	☐ Stroke	☐ Heart Attack	☐ Seizures
☐ Arthritis	☐ Blood clots in legs	☐ Kidney Disease	☐ Asthma	☐ Emphysema	☐ Blood clots in lungs
☐ Cancer (type):		☐ Chronic Sinus Problems	☐ Other:		

Are you currently bothered by:

☐ Constipation	☐ Headache	☐ Joint Pain	☐ Painful passing of urine	☐ Cuts slow to heal
☐ Diarrhea	☐ Dizziness	☐ Joint Stiffness	☐ Difficult urination	☐ Skin Rashes
☐ Stomach Pain	☐ Forgetfulness	☐ Fever	☐ Frequent Urination	☐ Bleeding frequently
☐ Heartburn	☐ Blurred vision	☐ Trouble walking	☐ Impotence/sexual concerns	☐ Bruising frequently
☐ Vomiting	☐ Double vision	☐ Swelling of feet		
☐ Loss of Appetite	☐ Depression	☐ Chest pain		
☐ Trouble Swallowing	☐ Insomnia	☐ Cough	If female, are you having menstrual periods?	☐ Breast Pain
	☐ Hearing Loss	☐ Wheezing	☐ Yes ☐ No	☐ Breast Discharge
	☐ Earaches	☐ Shortness of Breath		☐ Breast lump
	☐ Ear Drainage			

Have you noticed any...

☐ blood in your stool ☐ blood in your urine ☐ coughing up blood ☐ recent unexplained weight loss

Any other problems not listed above?

Habits:

Do you smoke? ☐ no - never

☐ no - but I did in past--When(list approx age begun): ________ and how long (# of years): ________________

☐ yes - if yes, how many packs/day? ______ since what age? ____________

Do you drink alcohol? ☐ no

☐ yes: ☐ daily or almost daily: how much ☐ 1-2 x/wk ☐ rarely or not at all

Labs & Tests Done Recently: check if:	Specify where this/these tests were done:
☐ you've had an EKG in the last 6 months	
☐ recent x-rays (what kind):	
☐ any blood tests in last 4 weeks	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing misleading or inaccurate information can adversely affect my medical care. It is my responsibility to inform my physicians of any changes in my health status.

*Patient Signature:*________________________________ *Date:*______________________________

If patient did not complete the above form, please list who provided the information and their relationship to the patient:

Signature:______________________________ Relationship to patient:__________________________

EVERGREEN SURGICAL PATIENT REGISTRATION INFORMATION

Please complete the following information:

LAST NAME	FIRST NAME M.I.	BIRTHDATE
		____/____/____
STREET ADDRESS	CITY, STATE, ZIP	SOCIAL SECURITY #
		______-______-______
TELEPHONE (AREA CODE)	MARITAL STATUS:	IF MARRIED, SPOUSES NAME:
( )	☐ Married ☐ Single ☐ Widowed ☐ Divorced	
CELL PHONE (AREA CODE)	E-MAIL ADDRESS	
( ) ☐ DON'T HAVE		
IF CHILD, PLEASE PROVIDE PARENT/GUARDIAN INFORMATION IN SHADED AREA:	Parent/Guardian Name(s):	
Telephone (*if different from above*)	Address (If different from above):	

EMERGENCY CONTACT *(Person who does not live with you)*

Name: Relationship: Phone: (   )

EMPLOYMENT INFORMATION:

Employer:

Occupation:

Work Address:

City/State/Zip: Telephone: (   ) - Ext.

Is this a work related injury? ☐ Yes ☐ No If yes, date of injury:____/____/____

INSURANCE INFORMATION

Medicare #:________________________ **Medical Assistance #:**________________________

Primary Insurance Company:________________________ Cardholders Name:________________________

Employer:________________ Group #:__________ Policy #:__________ Cardholder's Birthdate: __________

Hospital Certification Required? ☐ Yes ☐ No Second Opinion Required? ☐ Yes ☐ No

Secondary Insurance Company:________________________ Cardholders Name:________________________

Employer:________________ Group #:__________ Policy #:__________ Cardholder's Birthdate: __________

Hospital Certification Required? ☐ Yes ☐ No Second Opinion Required? ☐ Yes ☐ No

If you have additional health insurance other than that listed above, please let us know.

*** If you'd like to have any unpaid charges billed to your Mastercard/VISA, please ask the staff for a form.***

REFERRAL SOURCE

Whom may we thank for referring you to us?____

OVER

PATIENT SIGNATURE ON FILE FOR MEDICARE CLAIMS AND ANY OTHER INSURANCE, INCLUDING MEDIGAP INSURANCE:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible, co-insurance or any other balance not paid by insurance.**

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my medical record.

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Medigap, private insurance and other health plans to Evergreen Surgical, S.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed:____ Date:____________

revised 9/1997, 10/2004, 7/2007, 5/2009 reviewed 7/2010, 11/2011
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