ATLANTIC SHORE SURGICAL ASSOCIATES-NEW PATIENT FORMS

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Referring Physician: _____ **Patient Name:** _____

Chief Complaints: _____

History of present illness: (Location, severity, duration and other symptoms):

_____

Medical History (Please list all):

_____

- ❑ **Diabetes**
- ❑ **Heart Problem**
- ❑ **Kidney Disease**
- ❑ **Bleeding tendency**
- ❑ **Hypertension**
- ❑ **Stroke**
- ❑ **COPD**
- ❑ **Cancer**

Previous Hospitalization/Surgeries/Colonoscopy: When?

_____

_____

_____

Social History:

Marital Status:	❑ **Single**	❑ **Married**	❑ **Divorced**	❑ **Widowed**
Tobacco:	❑ **NO**	❑ **YES**	❑ **Quit**	_____ **Packs Per Day**
Alcohol:	❑ **NO**	❑ **YES**	❑ **Quit**	
Drugs:	❑ **NO**	❑ **YES**	**Name:** _____	

Family Medical History:

Relationship	**Age**	**Disease**	**Cause of death, if diseased**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Sibling:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Reviewed by: _____ **Date:** _____

(For Physician Signature Only)

Patient's Name: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

ALLERGY/MEDICATION SHEET

ALLERGIES: _____

HOME MEDICATIONS:
(List all prescription medications, over the counter medications, and herbal supplements / vitamins / fish oil etc.)

MEDICATION NAME	DOSE	FREQUENCY

Patient's Signature: _____ **Date:** _____

P.O.A./Guardian's Signature: _____

ATLANTIC SHORE SURGICAL ASSOCIATES

PATIENT DISCLOSURE INFORMATION

In General, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The Individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of an individual's home

I wish to be contracted in the following manner (check all that apply):

- ❑ **Home telephone #** _____
- ❑ OK to leave a message with detailed information
- ❑ Leave the message with call back number only
- ❑ Other_____

- ❑ **Work telephone #** _____
- ❑ OK to leave a message with detailed information
- ❑ Leave the message with call back number only
- ❑ Other_____

- ❑ **Written Communication**
- ❑ Ok to mail to home address
- ❑ Ok to mail to my work address
- ❑ Ok to fax to this number_____

- ❑ **Person authorized to receive this info:**
1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

By signing this document, I Acknowledge that I have received a copy of the Atlantic Shore Surgical Associates, P.A. notice of privacy practices.

Patient's Signature: _____ **Date:** _____

Patient's Name (Print): _____ **Date of Birth:** _____

P.O.A./Guardian's Signature: _____

Review of Symptoms: Please check anything in personal history that applies

Constitutional Symptoms
- ❑ Good General Health
- ❑ Recent weight change
- ❑ Fever
- ❑ Fatigue
- ❑ Headaches

Eyes:
- ❑ Eye disease or injury
- ❑ Wear Glasses/contact lenses
- ❑ Blurred or double vision
- ❑ Glaucoma

Cardiovascular:
- ❑ Heart trouble
- ❑ Chest pain or Angina
- ❑ Palpitation
- ❑ Shortness of breath w/ walking
- ❑ Swelling of feet, ankles or hands

Ears/Nose/Mouth/Throat
- ❑ Hearing loss or ringing in ear
- ❑ Earaches or drainage
- ❑ Chronic sinus problem or rhinitis
- ❑ Nose bleeds
- ❑ Mouth sores
- ❑ Bleeding gums
- ❑ Bad breath or bad taste
- ❑ Sore throat or voice change
- ❑ Swollen glands in neck

Gastrointestinal:
- ❑ Loss of appetite
- ❑ Change of bowel movements
- ❑ Nausea or vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bleeding per rectum
- ❑ Abdominal pain

Neurological:
- ❑ Headache
- ❑ Dizziness
- ❑ Convulsions
- ❑ Numbness or tingling
- ❑ Tremors
- ❑ Paralysis
- ❑ Stroke
- ❑ Head Injury

Musculoskeletal:
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle weakness
- ❑ Muscle pain/cramps
- ❑ Back pain
- ❑ Cold extremities
- ❑ Difficulty in walking

Integumentary (Skin and breast):
- ❑ Rash or itching
- ❑ Change in skin color
- ❑ Varicose veins
- ❑ Breast pain
- ❑ Breast lump
- ❑ Nipple discharge

Endocrine:
- ❑ Glandular or hormonal problem
- ❑ Thyroid disease
- ❑ Diabetes
- ❑ Excessive thirst or urination
- ❑ Heat or Cold intolerance
- ❑ Dry skin

Psychiatric:
- ❑ Memory loss or confusion
- ❑ Nervousness/Anxiety
- ❑ Depression
- ❑ Insomnia

Respiratory:
- ❑ Chronic or frequent coughs
- ❑ Spitting up blood
- ❑ Shortness of breath
- ❑ Asthma or Wheezing

Hematologic/Lymphatic:
- ❑ Slow to heal after cuts
- ❑ Bleeding or bruising tendency
- ❑ Anaemia
- ❑ Past transfusion
- ❑ Enlarged glands

Genitourinary:
- ❑ Frequent urination
- ❑ Burning or painful urination
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Kidney stone
- ❑ Sexual difficulty

Male
- ❑ Testicular pain

Female
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Vaginal Discharge

Age at first period _____
Age at last period _____
# of pregnancies _____
Age at first pregnancy _____
Date of last pap smear _____

Allergic/Immunologic:
- ❑ History of skin reaction or adverse reaction to:
- ❑ Penicillin
- ❑ Tape
- ❑ Latex
- ❑ Morphine, Demerol, other narcotics
- ❑ Novocaine or other Anaesthetics
- ❑ Other Drug or Medication
- ❑ Iodine
- ❑ Aspirin
- ❑ Iodine or antiseptic
- ❑ Shellfish
- ❑ IV Contrast

Currently taking any blood thinners, anti-platelet medications like Aspirin, Plavix, Anti-inflammatory pain medications or fish oil:

_____

Patient's Name: _____ **Reviewed by:** _____ **Date:** _____
(For Physician Signature Only)