



STAT Label Here

Patient ID Label Here

PATIENT DEMOGRAPHICS

Street Address: _____

City, State, Zip: _____ Email Address: _____

Home Phone: _____ Date of Birth: _____

Work Phone: _____ Social Security No.: _____

Cell Phone: _____ Marital Status: S M W D

Employer: _____ Occupation: _____

Emergency Contact: _____

Relationship to You: _____ Phone: _____

Primary Insurance:

Insurance Company: _____ Policy Holder Name: _____

Claims Address: _____ Policy Holder SSN#: _____

City, State, Zip: _____ Policy Holder DOB: _____

Insurance Phone No.: _____ Relationship to Patient: _____

Insurance ID No.: _____ Group No.: _____

Secondary Insurance:

Insurance Company: _____ Policy Holder Name: _____

Claims Address: _____ Policy Holder SSN#: _____

City, State, Zip: _____ Policy Holder DOB: _____

Insurance Phone No.: _____ Relationship to Patient: _____

Insurance ID No.: _____ Group No.: _____

Please list any individual(s) you authorize our office to release your medical information to:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Signature: _____ Date: _____



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PATIENT INFORMATION

Date: _____

Medical History:

Do you prefer to be called by another name? _____

Age: _____ Gender: _____ Height: _____

Present Weight: _____ Usual Weight: _____ Greatest Weight: _____

Primary Care / Family Doctor: _____

Phone Number: _____

Doctor who referred you: _____

Phone Number: _____

Have you ever been seen by a Cardiologist (Heart Doctor)? Yes No

Doctor's Name: _____ Phone: _____

Reason: _____

Have you ever been seen by a Pulmonologist (Lung Doctor)? Yes No

Doctor's Name: _____ Phone: _____

Reason: _____

Are there other Doctors you are currently seeing? Yes No

Doctor's Name: _____ Phone: _____

Reason: _____ Last Seen: _____

Doctor's Name: _____ Phone: _____

Reason: _____ Last Seen: _____

What is the reason for your visit? _____

What are your symptoms and when did they start? _____



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Please list your Hospitalizations:

Illness Kind / Type	Year	Hospital / City
_____	_____	_____
_____	_____	_____
_____	_____	_____

Operation Kind / Type	Year	Hospital / City
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

	Stroke	High Blood Pressure	Diabetes	Heart Disease	Cancer / Type	Age at Death / Cause of Death
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____

Other Family Medical Problems: _____

Do you currently smoke? Yes No How much per day: _____

Have you smoked in the past? Yes No When did you stop: _____

Do you currently drink alcohol? Yes No How much per week: _____

Do you currently use drugs? Yes No

Do you or have you in the past abused drugs? Yes No

For Women:

Are you pregnant? Yes No Expected delivery date: _____

Date of last menstrual period? _____



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Current Medications – Prescription and Non-Prescription:

Please list all over the counter (non-prescription) and prescription medications including Vitamins and Herbal Supplements that you are currently taking. Also, remember to include those that can cause bleeding. Some examples are (but not limited to) Aspirin, Ibuprofen, Excedrin, Advil, Motrin, Aleve, Orudis, etc.

Name of Medication	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If your answer is yes to any of the below, please list above.

- Do you take Aspirin? Yes No
- Do you take Advil (Ibuprofen)? Yes No
- Do you take ANY Vitamins? Yes No
- Do you take Diet Medications / Herbs / Tea? Yes No
- Do you take St. Johns Wort, Melatonin or Ephedra? Yes No
- Do you take Ginseng, Kava, Valerian or Black Cohosh? Yes No
- Do you take Garlic Supplements, Ginko, Fish Oil or Vitamin E? Yes No

Allergies:

- Peanut Allergy Latex Allergy Shellfish Allergy
- No Drug Allergies Yes Drug Allergies (Please Explain / List All Below)



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Health History:

<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Hearing Loss	<input type="checkbox"/> Y <input type="checkbox"/> N Depression	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Poor Vision	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Illness	<input type="checkbox"/> Y <input type="checkbox"/> N Phlebitis
<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Stones	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain
<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Infection	<input type="checkbox"/> Y <input type="checkbox"/> N Burning on Urination	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Urination	_____ # of Night Urination	<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Heart Beat
<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma / Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Varicose Veins
<input type="checkbox"/> Y <input type="checkbox"/> N Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat / Cough
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N HIV	<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Nosebleeds
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Alcoholism	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer
<input type="checkbox"/> Y <input type="checkbox"/> N Gout	<input type="checkbox"/> Y <input type="checkbox"/> N Chills / Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Rash
<input type="checkbox"/> Y <input type="checkbox"/> N Breast Lump	<input type="checkbox"/> Y <input type="checkbox"/> N Breast Pain	<input type="checkbox"/> Y <input type="checkbox"/> N Nipple Discharge
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Blood in Stool	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice
<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N Poor Appetite
<input type="checkbox"/> Y <input type="checkbox"/> N Nausea / Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N Gallbladder Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Gallstones
<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Pain	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Heartburn
<input type="checkbox"/> Y <input type="checkbox"/> N Change in Bowel Habits	<input type="checkbox"/> Y <input type="checkbox"/> N Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea
<input type="checkbox"/> Y <input type="checkbox"/> N Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Anemia	

Please Explain all Yes Answers:

Reaction to Anesthesia? Never Had Anesthesia Yes (Please Explain Below) No

Reviewed with patient:

Daryl D. Wier, M.D. FACS / Date / Time