Paris Surgical Specialists, P.L.L.C

PATIENT INFORMATION *(Please Print)*

Patient Name: _____ **Date of Birth:** _____ **Gender:** *Male* ☐ *Female* ☐

Mailing Address: _____
City *State* *ZIP*

Email: _____ **Phone:** _____ **Cell:** _____ **SS#:** _____

Marital Status: *Married* ☐ *Single* ☐ **Employer:** _____ **Occupation:** _____

Spouse Name: _____ **Spouse Employer:** _____

Spouse SS#: _____ **Spouse Date of Birth:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Pharmacy: _____

EMERGENCY CONTACT *(A different phone number from your own)*

Name: _____ **Phone:** _____ **Relationship To Patient:** _____

MINOR CHILDREN

Person Responsible For The Account: _____

Address: _____

Phone: _____ **Employer:** _____ **Employer Phone:** _____

Social Security #: _____ **Date of Birth:** _____

INSURANCE

Primary Insurance: _____ **Policyholder Name:** _____

Relationship To Patient: _____ **Policyholder Date of Birth:** _____

Policyholder SS#: _____ **Policyholder Employer:** _____

Secondary Insurance: _____ **Policyholder Name:** _____

Relationship To Patient: _____ **Policyholder Date of Birth:** _____

Policyholder SS#: _____ **Policyholder Employer:** _____

In order to comply with the Health Insurance Portability and Accountability Act, Paris Surgical Specialists, P.L.L.C. has a written Notice of Privacy Practices stating how a patient's Protected Health Information may be used to carry out treatment, payment, and healthcare operations. I understand that this Notice will be made available to me by request and can also be viewed in the clinic lobby.

By signing below, I certify that the above information is complete and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Patient Name: _____ **Date:**_____

Who is you regular doctor? _____

Please list all medications you are taking. Pharmacy: _____

Medication	Strength	How often you take it?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

What medications are you allergic to and what are the symptoms of the allergy?

Medication	Symptom to the allergy

Have you had any operations? When? (approximately)

- ❑ Stomach Surgery(including surgery for ulcers, reflux, etc.)……..……_____
- ❑ Intestine or Colon surgery…….……_____
- ❑ Thyroid/Parathyroid Surgery……...…_____
- ❑ Rectal or Hemorrhoid surgery…….……_____
- ❑ Heart Surgery……...…_____
- ❑ Heart Catheterizations(cath's including stents or angioplasty)……..……_____
- ❑ Weight loss or Bariatric Surgery……...…_____
- ❑ Endoscopy (including Colon/large intestine, Esophagus, Stomach, or EGD)…_____
- ❑ Operations on blood vessels (including stents or regular surgery)……_____
- ❑ Breast Surgery (including biopsy, mastectomy, augmentation, or reduction)…_____
- ❑ Female Surgery (including hysterectomy, scopes, or c-sections)……_____
- ❑ Kidney or Bladder surgery……_____
- ❑ Spine Surgery (including disc or fusions……_____
- ❑ Orthopaedic Surgery (including scopes, joints replacement, etc) ……_____
- ❑ Chest or Lung Surgery._____ Tonsil or Sinus Surgery_____
- ❑ Hernia Surgery ……...._____ Eye Surgery…….._____
- ❑ Appendix……..._____ Gallbladder……..._____
- ❑ Brain Surgery……...._____ Skin Operations…..._____
- ❑ Other: _____

Patient Name: _____ **Date:**_____

Do you have any of the following?

- ❑ High blood pressure
- ❑ Coronary artery disease
- ❑ Heart attack How many? _____
  When was last one? _____
- ❑ Angina
- ❑ Congestive Heart Failure
- ❑ COPD (Chronic Obstructive Pulmonary dx)
- ❑ Emphysema
- ❑ Chronic Bronchitis
- ❑ Asthma
- ❑ Sleep Apnea
- ❑ Tuberculosis (TB)
- ❑ Hepatitis
- ❑ Cirrhosis
- ❑ Gallstones
- ❑ Pancreatitis
- ❑ Ulcers
- ❑ Hiatal Hernia
- ❑ Stricture
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Hemorrhoids
- ❑ Diverticulosis
- ❑ Colon Polyps
- ❑ Reflux
- ❑ Diabetes (circle one)
  Diet Insulin Oral meds
- ❑ Kidney Stones
- ❑ Renal Failure
- ❑ Prostate Enlargement
- ❑ High Cholesterol
- ❑ High Triglycerides
- ❑ Gout
- ❑ Blood clots in leg veins
- ❑ Blockage in arteries? Where _____
- ❑ Aneurysms
- ❑ Stroke
- ❑ Migraines
- ❑ Seizures
- ❑ Parkinson's Disease
- ❑ Alzheimer's Disease
- ❑ Arthritis
- ❑ Ulcerations/Sores on feet or legs
- ❑ Heart Disease
- ❑ Varicose Veins
- ❑ Gangrene
- ❑ Palpitations
- ❑ Peripheral Vascular Disease

Any other medical problems?

_____
_____
_____
_____
_____

<u>Woman Only</u>

Number of pregnancies _____
Number Miscarriages _____
Age beginning periods _____
Age of menopause _____
Did you breast feed? Yes No
Do you take estrogens? Yes No
Do you take birth control pills? Yes No

Do you have any of the follow problems?

- ❑ Breast pain or soreness
- ❑ Endometriosis
- ❑ Discharge from nipple
- ❑ Abnormal menstrual periods
- ❑ Abnormal vaginal bleeding
- ❑ Vaginal Discharge

Have you had or do you have any type(s) of cancer?

- ❑ Skin
- ❑ Melanoma
- ❑ Breast
- ❑ Lung
- ❑ Colon
- ❑ Stomach
- ❑ Cervical
- ❑ Uterine
- ❑ Ovary
- ❑ Prostate
- ❑ Leukemia
- ❑ Lymphoma

Other _____
_____
_____
_____

Patient Name: _____ **Date:**_____

Family History (disease's that run in you family)

- ❑ Breast cancer
- ❑ High blood pressure
- ❑ Colon cancer
- ❑ High cholesterol
- ❑ Thyroid cancer
- ❑ Psychiatric illness
- ❑ Peripheral Vascular Disease
- ❑ Joint problems
- ❑ Kidney Disease
- ❑ Headaches/Migraines
- ❑ Coronary Artery Disease
- ❑ Varicose Veins
- ❑ Thyroid Disease
- ❑ Ovarian cancer
- ❑ Heart attack
- ❑ Diabetes
- ❑ Stroke
- ❑ Obesity
- ❑ Other _____

Smoking

	(Circle one)		
Do you smoke currently?	Yes	No	# of packs? _____
If not, have you ever smoked?	Yes	No	How many years?_____
Have you quit smoking?	Yes	No	
Do you use any other form of tobacco?	Yes	No	

Alcohol and other drugs

Do you drink alcohol?	Yes	No	How Often? _____
Have you ever had a drinking problem?	Yes	No	
Have you ever used illegal/street drugs?	Yes	No	
Have you ever had an addiction?	Yes	No	

Other

Marital Status (circle one) Married Single Divorced Widowed

Highest grade completed _____ Occupation _____

Do you have any of the following ongoing problems

- ❑ Unintentional or unexplained weight loss
- ❑ Loss of appetite
- ❑ Severe tiredness or fatigue
- ❑ Lack of stamina, Strength or endurance
- ❑ Blurred vision
- ❑ Double vision
- ❑ Ringing in ears
- ❑ Drainage from ears
- ❑ Nosebleeds
- ❑ Sinus trouble
- ❑ Hoarseness
- ❑ Painful or difficult swallowing
- ❑ Chronic Cough
- ❑ Coughing up blood or bloody mucous
- ❑ Jaundice or yellow jaundice
- ❑ Indigestion
- ❑ Stomach fluid washing into mouth
- ❑ Chronic cough after going to bed
- ❑ Swelling
- ❑ Depression/anxiety
- ❑ Vomiting blood
- ❑ Change in bowel habits
- ❑ Frequent constipation or diarrhea
- ❑ Frequent nausea or vomiting
- ❑ Abdominal distention or swelling
- ❑ Loss of control of urine
- ❑ Blood in urine
- ❑ Burning with urination
- ❑ Swollen glands
- ❑ Abnormal bleeding
- ❑ Back pain
- ❑ Headache
- ❑ Slurred speech
- ❑ Loss of balance
- ❑ Serious tremor
- ❑ Memory loss
- ❑ Prolonged exposure to sun
- ❑ Blistering sunburn
- ❑ Shortness of Breath
- ❑ Muscle pain/ Joint pain