Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

X _____ _____
Signature of patient (or parent, if minor) Patient number

POTTSTOWN SURGICAL ASSOCIATES, LTD
1329 E. HIGH ST. SUITE 1 POTTSTTOWN, PA 19464
610-326-8400 FAX: 610-323-8215

Patient Name_____ DOB_____ Date_____

TOBACCO ASSESSMENT

Smoking Status: ☐Current every day ☐Heavy ☐Light ☐Former ☐Never ☐Unknown
☐Received Counseling on smoking cessation
☐Rx therapy for smoking cessation
☐Discussed smoking cessation strategies
☐Second Hand Smoke Exposure
☐Tobacco User
☐Packs Per Day_____
☐Years Smoked_____
☐Date Quit Smoking_____

SOCIAL HISTORY

Alcohol Use:☐Non-drinker ☐Occasional ☐Social ☐Moderate ☐Heavy ☐Recovering Alcoholic ☐Never
☐Received counseling regarding alcohol cessation
Drug Use:☐Yes ☐No
Type:_____
Status:☐Never ☐Occasional ☐Daily ☐Prior Use ☐History of drug abuse
☐Tattoos ☐Body Piercings ☐Caffeine Use
☐Native Language_____ ☐Marital Status_____
☐Occupation_____ ☐Religion_____
☐Education Level_____ ☐Exercise habits_____

PREVENTIVE CARE

Last Pap Smear_____

Last Complete Physical Exam_____

Last Colonoscopy_____

Last Flexible Sigmoidoscopy_____

Last Stool Occult Blood Test_____

Last Tuberculin PPD Test_____

Last Mammography_____

Last Flu Vaccine_____

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Patient Name_____ DOB_____ Date_____

PAST MEDICAL HISTORY

- ☐Alcoholism
- ☐Anemia
- ☐Arthritis
- ☐Asthma
- ☐Back Pain
- ☐Cardiac Pacer
- ☐Depression
- ☐DM Type 2
- ☐DM Type 1
- ☐Emphysema
- ☐Glaucoma
- ☐Gout
- ☐Heart Attack
- ☐Heart Murmur
- ☐High Cholesterol
- ☐Hypertension
- ☐HIV
- ☐Kidney Disease
- ☐Kidney Failure
- ☐Kidney Infections
- ☐Kidney Stone
- ☐Migraines
- ☐Multiple Sclerosis
- ☐Osteoporosis
- ☐Parkinson's Disease
- ☐Phlebitis
- ☐Pneumonia
- ☐Progressive Neurological Disorder
- ☐Pulmonary Disease
- ☐Rheumatic fever
- ☐Seizures/Epilepsy
- ☐Skin Cancer
- ☐STD
- ☐Stroke
- ☐Terminal Illness
- ☐Tuberculosis
- ☐Thyroid Disease
- ☐No medical problems
- ☐Other_____

GENERAL FAMILY HISTORY

- ☐Denial of any knowledge of family history
- ☐Adopted
- ☐Alcoholism
- ☐Anemia
- ☐Asthma
- ☐Arthritis
- ☐Birth Defects
- ☐Bleeding Disorder
- ☐Cardiovascular Disease
- ☐Emphysema
- ☐Unknown Maternal Hx
- ☐Cancer
- ☐Cholesterol Problems
- ☐Crohn's Disease
- ☐Depression
- ☐Diabetes
- ☐Hypertension
- ☐Kidney Disease
- ☐Unknown Paternal Hx
- ☐Liver Disease
- ☐ Osteoporosis
- ☐Pulmonary Disease
- ☐Stomach Ulcer
- ☐Stroke
- ☐Thyroid Disease
- ☐Other_____

PAST SURGICAL HISTORY

- ☐No Prior Surgical History
- ☐Appendectomy
- ☐C-Section
- ☐Cholecystectomy
- ☐Colon Resection
- ☐EGD
- ☐ERCP
- ☐Gallbladder
- ☐Groin Hernia
- ☐Hemorrhoids
- ☐Hiatal Hernia
- ☐Heart Surgery
- ☐Hysterectomy
- ☐Joint Replacement
- ☐Kidney
- ☐Liver Biopsy
- ☐Mastectomy
- ☐Myomectomy
- ☐Obesity Surgery
- ☐Oophorectomy
- ☐Prostate
- ☐Stomach
- ☐Thyroid
- ☐Tonsil/Adenoidectomy
- ☐Tubal Ligation
- ☐Other_____

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Patient Name_____ DOB_____ Date_____

Height_____ Weight_____ BP_____ Pulse_____

MEDICATIONS(please list name, dose and frequency)

☐No current medications

ALLERGIES(please list reaction if known)

☐No Known Drug Allergies