PATIENT MEDICAL HISTORY

CONFIDENTIAL INFORMATION: information contained herein will not be released except when you have authorized us to do so. Please answer **all** questions to the best of your knowledge. The information that you provide will be used by your doctor in decisions regarding your care.

Patient Information

Name: ____________________ Date of Birth: _________ Age: ____

Physician Information

Referred By: ____________________

Primary Care Physician: ____________________

Medical Information

Reason for visit: ____________________

If this is for a medical reason, list date of onset: ____________________

Height: ___________________ Weight: ____________________

Do you currently have, or have you ever had any of the following? (Please circle – if "yes", give date of onset/occurrence)

AIDS or HIV+	No Yes ___________________	Heart Condition	No Yes ___________________
Anxiety	No Yes ___________________	Hepatitis	No Yes ___________________
High blood pressure	No Yes ___________________	Weight loss/gain	No Yes ___________________
Asthma	No Yes ___________________	Kidney disease	No Yes ___________________
Back Problems	No Yes ___________________	Migraines	No Yes ___________________
Bleeding disorder	No Yes ___________________	Seizure Disorder	No Yes ___________________
Blood clotting disorder	No Yes ___________________	Stomach ulcers	No Yes ___________________
Cancer	No Yes ___________________	Stroke	No Yes ___________________
Thyroid disorder	No Yes ___________________	Heart attack	No Yes ___________________
Depression	No Yes ___________________	Tuberculosis	No Yes ___________________
Diabetes	No Yes ___________________		

Other serious medical conditions or injury that you have or have had, not mentioned above:

____

____

Have you ever had surgery? (If "yes", please list the name of the operation and the date it was performed):

____

____

____

Have you ever had any complications from anesthesia? (If "yes", please explain):

____

____

____

Social History

Do you currently smoke? ____ If "yes": How much? ______ If "no": Have you ever smoked? ____ If "yes": When did you quit? _______
Do you currently Vape? _____ If "yes": How much? _______ If "no": Have you ever vaped? ______If "yes": When did you quit? ______
Do you currently use marijuana or cannabis products? _________ If "yes": How much? _______________
If "no": Have you ever used marijuana or cannabis products? _________ If "yes": When did you quit? _________
Do you regularly drink alcohol? Yes / No If "yes": How much? _________________ How often? _________________

Allergies

Do you have any known allergies to medications, iodine/contrast dye, or LATEX? _______ If "yes", please list:
____
____

For women only:

Is there a chance you might be pregnant? _______ Are you still having regular monthly periods? ______Date of last period? ________
Date of last mammogram: ________ Results: __________ How many children do you have? ______________
We recommend routine breast and pelvic exams by your physician for all adult females.

Are you presently taking any of the following medications? *(If "yes", please circle and list the name of the medication).*

Accutane (Isotretinoin)	__________________________	Hormones	__________________________
Antibiotics	__________________________	Insulin or diabetic pills	__________________________
Anxiety/Depression Meds	__________________________	Laxatives	__________________________
Arthritis medicine	__________________________	Retin-A	__________________________
Aspirin, Bufferin, Anacin	__________________________	Seizure Meds	__________________________
Birth control pills	__________________________	Sleeping pills	__________________________
Blood pressure pills	__________________________	Steroids	__________________________
Blood thinning pills	__________________________	St. Johns Wart	__________________________
Cough medicine	__________________________	Thyroid medicine	__________________________
Digitalis	__________________________	Water pills	__________________________
Headache meds	__________________________	Weight reducing pills	__________________________
Herbal Supplement	__________________________		

Other vitamins, supplements, or medications not listed above: ____

Family Medical History

If a blood relative has/had any of the following conditions, please circle and give relationship (blood relatives includes siblings, parents, grandparents, children):

Bleeding tendency	__________________________	Heart disease	_________________________
Blood clotting disorder	__________________________	Diabetes	_________________________
Breast cancer	__________________________	Stroke	_________________________

Please list anything about yourself or your health that you think would be important for the doctor to know: _______________
____
____
____
____

PATIENT REGISTRATION FORM

Name: ____ Date of Birth: ____________
Address: ____
Sex: Female Male Social Security Number: ______-_____-______ Marital Status: _______________
Home No.: _______________________________ Cell No.: ______________________________________
E-Mail: ____
Emergency Contact Name: _______________________________ Phone Number: ____________________
*** If patient is a minor:** Name of person financially responsible: ______________________________________
Relationship to Patient: ____
How Did You Hear About Sullivan Surgery & Spa? ____
****

Insurance Carrier (PRIMARY): ____
Group #: ____________________ Member/ID #: ____________________ Employer: _________________
Date Effective: __________________________________
Policy Holder's Name: ____ Date of Birth: ______________
Social Security Number: ______-_____-______ Sex: Female Male Relationship: ______________
Secondary Insurance Carrier: ____
Group #: ________________ Member/ID #: ____________________ Employer: ____________________
Specialist Co-pay amount: ___________________ Date Effective: ___________________________________
Policy Holder's Name: ____________________________________ Date of Birth: __________________
Social Security Number: ______-_____-______ Sex: Female Male Relationship: ________________
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______ * I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-pays, or coinsurances. *I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. *I authorize my provider's office to contact me by telephone to remind me of my appointments.

Patient/Guardian Signature: ____ **Date:** ________________

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery or a procedure. The photographs will be taken by one of the members of the Sullivan Surgery & Spa medical staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of insurance pre-authorization, office and hospital medical charts, and any necessary medical treatment.
I hereby give my consent for Sullivan Surgery & Spa to use the photographs under the following conditions:
Please choose one of the following options and initial

(Please initial) ______ I authorize my photographs to be used for the purposes of: Medical Seminars, website publication, social media and/or office photo albums. All efforts will be made to ensure patient anonymity and confidentiality. No names or identifying references will be made in conjunction with published photography.

(Please initial) ______ I authorize my photographs to be used only for my medical record, my surgery record and insurance purposes of my surgery with Surgeon. I understand these photos *will not* be used on the office website or in any publications.

Patient/Guardian Signature: ____ **Date:** ________________