DANA L. REISS, M.D., FACS

ADVANCED LAPAROSCOPIC AND BARIATRIC SURGERY

Patient Identification and Medical Information

Completed on _____ *(date)*

Name: _____ ***Home phone:*** (___) _____

Address: _____ ***Cell phone:*** (___) _____

City,State,Zip: _____ ***Age:*** _____

Patient's Soc Sec Number: _____ ***Date of Birth:*** _____

Patient's occupation: _____ ***Marital Status:*** _____

Patient's employer: _____ ***Work phone:*** (___) _____

Employer address: _____

City,State,Zip: _____

Emergency Contact: _____ ***Phone:*** (___) _____

Responsible party: _____ ***SSN:*** _____

Date of Birth: _____

Employer: _____ ***Work phone:*** (___) _____

Name of Insurance Company: _____

Policy Holder: _____ ***Relationship:*** _____

Policy number: _____ ***Group number:*** _____

Medicare number: _____ ***Medicaid number***: _____

Do you have a secondary insurance?..... yes/no

Name of secondary Ins.: _____ ***Policy Holder DOB:*** _____

Policy Holder: _____ ***Policy number:*** _____

Who is your primary care physician? _____

Dr.'s phone: (___) _____ ***Date of most recent visit***

Physician address: _____ ***with PCP:*** _____

City,State,Zip: _____

Who referred you to our practice? _____

MD Comments

Why are you seeing the doctor <u>today</u>?

_____
_____
_____
_____
_____

When did the problem begin?

_____
_____
_____

How often do you have the problem?

_____
_____

Have you had the problem in the past?

_____
_____

Is there anything that seems to bring the problem on (food, movement, stress, etc)?

_____
_____

What makes the problem better? Worse?

_____
_____

<u>MD Comments</u>

Past Medical History
(Please list any medical problems you may have such as diabetes, high blood pressure, etc)

Past Surgical History
(Please list any surgeries you have had in the past and the approximate year you had the surgery.)

Are you allergic to any medicines? What kind of reaction do you Have (rash, itching, etc)

Please list all of the medications you are currently taking. Please include any over-the-counter medicines as well as vitamins, herbs, etc.

Social History

Are you: Single Married Divorced

Do you have children? _____ If so please list their names and ages.

Are you currently employed? _____ If so, please describe your job.

Do you smoke? _____ How much? _____
How long have you been a smoker? _____

Do you drink alcohol? _____ How often? _____

Do you use drugs like marijuana, cocaine, etc? _____

Review of Systems
Have you recently experienced any of the following?

	Yes	No		Yes	No
Unintentional weight loss	☐	☐	Recurrent pneumonia	☐	☐
Excessive fatigue	☐	☐	Asthma attack	☐	☐
Unexplained fevers	☐	☐	Prolonged diarrhea	☐	☐
Night sweats	☐	☐	Prolonged constipation	☐	☐
Neck swelling	☐	☐	Blood in your stools	☐	☐
Swallowing difficulty	☐	☐	Dark, sticky stools	☐	☐
Blurry vision	☐	☐	Muscle aches	☐	☐
Tooth pain	☐	☐	Muscle spasms	☐	☐
Chest pain	☐	☐	Joint pain	☐	☐
Heart skips a beat	☐	☐	Constant headaches	☐	☐
Shortness of breath	☐	☐	Slurred speech	☐	☐
Do you have to sleep on multiple pillows?	☐	☐	Weakness in one arm or leg	☐	☐
Seizures	☐	☐	Persistent skin rashes	☐	☐
Anemia	☐	☐	New or changing mole	☐	☐
Recurrent urinary infections	☐	☐	Vaginal/penile discharge	☐	☐
Difficulty urinating	☐	☐	Burning with urination	☐	☐
Irregular periods	☐	☐	Pain with your periods	☐	☐
Breast lump	☐	☐	Nipple discharge	☐	☐

Permission for release of information and statement of financial responsibility:
To the best of my knowledge, this information and the medical history that I report are correct. I authorize the physicians and staff of Surgical Consultants of San Antonio to release my demographic and medical information to insurance companies as necessary for payment and to referring doctors as necessary for continuity of care. I understand that in case my insurance company denies payment for the services rendered, I will be personally responsible for full payment to Surgical Consultants of San Antonio.

Patient signature _____ Date _____