PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION: **DATE:**________________________

Patient First Name: ____________________ MI: _____ Last Name: ________________________

Date of Birth: _____________________ E-mail address: _________________________________

Address: ____ Apt: ________

City: _________________________________ State: __________________ Zip: ____________

Best phone #: (___) ______________________ Alternate phone#: (___)____________________

Emergency Contact: ________________________________ Phone #: _______________________

Social Security #: __________________________ M or F Marital Status: _____________

Patient's Employer: ____

Employer Address: ____________________________________ Employer Phone #: ___________

City: ____________________________________ State: __________________ Zip: ____________

Referring Physician: ________________Family Physician: __________________Ph#______________

Patient Pharmacy: ______________________ Address: ___________________________________

BILLING INFORMATION: (***if other than patient***)

First Name: ___________________________ MI: ________ Last Name: ____________________
Address: ____ Apt: ________
City: ___________________________________ State: ___________________ Zip: ____________
Best Phone#: (___)______________________ Alternate Phone#: (___)_______________________

INSURANCE INFORMATION:

Primary Insurance: ____
Group Number: _____________________ Policy #: _____________________________________
Subscriber Name: ____
Subscriber Sex: _________________________ DOB: ___________ SSN: ______________________
Subscriber Employer: ____
Employer Address: ____
City: ____ State: _____________________ Zip: ________

Secondary Insurance: ____
Group Number: _____________________ Policy #: _____________________________________
Subscriber Name: ____
Subscriber Sex: _________________________ DOB: _____________ SSN: _____________________
Subscriber Employer: ____
Employer Address: ____
City: ____________________________________ State: _____________________ Zip: ____________

Rev. 8/15/17

Huntsville Surgical Associates

PMSF/Review of Systems

Patient Name: ______________________________ Date of Birth:________ Date: ___________

Medical History:

Past Medical History:	
Allergies:	Latex Allergy?
Previous Operations/Dates:	
Serious Injuries:	Residual Disability?

Social History:

Marital Status: Single Married Divorced Widowed (circle one)		
Children: Yes No	Ages:	
Smoke: Yes No	How much?	When did you quit?
Drink alcoholic beverages? Yes No	Type & Amount:	

Family History: Is there a history in your immediate family of (*circle all that applies*):

Diabetes	Cancer	Heart attack before age 60	Stroke before age 60	High Cholesterol	Sudden Death
Seizures	Bleeding Disorders	TB	Rheumatic Disease	Asthma	Kidney Stones	Anemia
High Blood Pressure	Glaucoma	Migraines	Dementia(Alzheimer's)	Hepatitis	

ROS: Do you or have you had persistent problems with any of the following?

	Yes	No		Yes	No
General:			**Musculoskeletal:**		
Change in appetite, fever, weight loss			Joint pain/swelling		
Change in energy level			Numbness/tingling		
Eyes:			Varicose veins		
Wear Glasses/Contacts			Phlebitis		
Blurred Vision			**Skin:**		
Cataracts			Rashes		
Last Eye Exam			Hair/nail problems		
Ears/Nose/Throat			Lumps		
Hearing loss			Masses		
Ringing			**Neuro/Psych:**		
Allergies			Headaches		
Sinus trouble			Dizziness		
Hoarseness			Memory loss		
Goiter/thyroid			Anxiety		
Swollen Glands			Depression		
Cardiovascular:			**Breast:**		
Chest pain w/exercise			Lumps		
Heart murmur			Nipple discharge		
Palpitations			Do self exam		
Swelling of ankles			**Endocrine:**		
Last Ekg			Hypothyroid		
Respiratory:			Hyperthyroid		
Persistent cough			Excessive thirst		
Shortness of breath			Diabetes		
Emphysema/bronchitis			**Hematologic/Lymphatic:**		
Pneumonia			Bruise easily		
Hemoptysis			Difficulty stopping bleeds		
Gastrointestinal:			Family history of bleeding		
Trouble Swallowing			Yellow jaundice		
Heartburn/Ulcer			Blood transfusion		
Vomiting			Enlarged lymph nodes		
Diarrhea			**Allergies:**		
Constipation			Seasonal allergies		
Bloody/black tarry stools			**Other:**		
Hemorrhoids					
Hepatitis					
Genitourinary:					
Frequent urination					
Leakage of urine					
Blood in urine					
Kidney stones					
Frequent infections					

Systems reviewed by me on this date: ______________________________Time:___________

Physician Signature

Huntsville Surgical Associates

List all Medications, including Over-the-Counter and Herbal

Patient Name____________________

Chart #__________

Today's Date	Drug	Dose	Last Dose	Route	How Often	Reason

Latex Allergy: No ☐ Yes☐

Drug/Food/Environmental Allergies: No □ Yes □

Allergy	Reaction