Today's Date: ________________ SS # ________________________ Weight __________ Height__________
Patient's Name____Age_____Birthdate____________
Address ____
Street City State Zip Code
Home Phone ________________ Work Phone________________ Cell Phone_______________________
Email ____Marital Status: ❑Married ❑Single ❑Divorced ❑Widow

Occupation______________________ Employer ____________________________ Phone ______________
Employer's Address ____

Were you referred by another Doctor? ❑ Yes ❑ No Doctor's Name __________________________________
Address ____ Telephone_____________________
Street City State Zip Code
Name and address of personal family doctor if different ____
Other Doctors____

INSURANCE INFORMATION

Insurance Company ____________________________________ Policy # ______________
Address ____ Group # ______________
Secondary Insurance ____________________________________ Policy # ______________
Address ____ Group # ______________
Medicare # ____________________________ Medicaid # ___________________________

IN CASE OF EMERGENCY

Name of nearest relative not living with you _________________________________ Phone ______________
Address ____ Relationship _____________

PRESENT COMPLAINT ____
HOW LONG HAVE SYMPTOMS BEEN PRESENT?____
____

MEDICAL HISTORY – list ALL medical problems

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

SURGICAL HISTORY – list ALL past surgeries

1. ______________________ YEAR _______
2. ______________________ YEAR _______
3. ______________________ YEAR _______
4. ______________________ YEAR _______
5. ______________________ YEAR _______

LIST ALL MEDICATIONS (include birth control pills, non-prescription drugs or herbal remedies) ❑ **NONE**

1) ____ 5) ____
2) ____ 6) ____
3) ____ 7) ____
4) ____ 8) ____

DID YOU EVER HAVE A COLONOSCOPY? ❑ Yes ❑ No

Female patients only

Date of last menstrual period __________ Are they regular ❑ Yes ❑ No Periods started at age ______________
Menopause at age _______ Have you ever had a mammogram ❑ Yes ❑ No Date ___________
How many children? ____________ Ages ____

FOR OFFICE USE ONLY Height________ Weight_________ BP ____________ Temp____________
Copy of Insurance Card ❑ Copy of Driver's License ❑

SOCIAL HISTORY

Do you smoke now? ❑Yes ❑No How many packs per day? _______ How many years? _________________
Did you ever smoke? ❑Yes ❑No How many packs per day? _______ How many years? _________________
When did you quit? ___________________________
Do you drink alcohol? ❑ Yes ❑No How much / week ___________
Do you drink coffee? ❑ Yes ❑ No Cups Per Day __________ **Drugs?** __________________________________

ALLERGIES (penicillin, sulfa, iodine, foods, etc.) and describe any reaction (rash, itching etc.) ❑ **NONE**

NAME	REACTION
1.	
2.	

FAMILY HISTORY (Use M=Mother, F=Father, S=Sister, B=Brother, G=Grandparent)
Has anyone in your family had the problem that brings you here? (who) ______________________________
Has anyone in your immediate family had any of the following diseases?
Diabetes ________________ High Blood Pressure ___________________ Heart Disease ___________________
Bleeding Disorders __________________ Breast Cancer _________________ Colon Cancer ________________
Ovarian Cancer ____________________ Other Cancers ____
Severe Obesity ________________ Blood Clotting Problems ______________ Anesthesia Problems __________

REVIEW OF SYSTEMS Do you suffer from any significant conditions? (Check all that apply)

❑ Weight change – how much ___________
❑ Diabetes
❑ High Blood Pressure
❑ Heart Attack/Heart Problems
❑ Heart Surgery/Angioplasty/Stent
❑ Chest Pain
❑ High Cholesterol/Triglycerides
❑ Strokes
❑ Tuberculosis
❑ Chronic Cough
❑ Asthma/Bronchitis/Emphysema
❑ Shortness of Breath or Sleep Apnea
❑ Blackouts/Fainting
❑ Convulsions
❑ Stomach Ulcers
❑ Colitis/Diverticulitis
❑ Gallbladder Disease
❑ Change in Bowel Habits
❑ Diarrhea
❑ Constipation
❑ Cancer/Type ______________________
❑ Arthritis
❑ Phlebitis/Leg Blood Clots
❑ Liver Disease/Hepatitis
❑ Blood Clotting Problems
❑ Drug or Alcohol Abuse
❑ Thyroid
❑ Bladder or Kidney Disease
❑ Prostate Problems
❑ Childhood diseases (chickenpox, measles, mumps, etc.):
❑ HIV/AIDS ❑ Hepatitis ❑ Syphilis
❑ Problems with anesthesia or surgery ____
❑ Do you bleed easily?

List any other: ____

AUTHORIZATIONS AND RELEASES

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, private insurance and other health plans to: R. Constantine M.D. **I understand that I am financially responsible for all charges whether or not paid by said insurance** and hereby authorize said assignee to release all information necessary to secure payment. **I hereby grant permission** for release of all medical records, documents, and associated information to Dr. R. Constantine or his authorized agent.

Patient Signature_______________________ **Print Name**________________________________

I verify the content and accuracy of the above information.

Date_________________ Signature ____