



Center of Surgical Specialists, P.C.
Advanced Knowledge. Expert Care.

Minor's Information Sheet

Child's Name: _____ Date Of Birth ____/____/____
 Address: _____ Apt#: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Social Security Number: _____
 Allergies to Medication: _____ Sex: Male/ Female

Mother's Information

Father's Information

Name: _____
 Social Security#: _____
 Date of Birth: ____/____/____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Employer: _____
 Work Phone: _____

Name: _____
 Social Security#: _____
 Date of Birth: ____/____/____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Employer: _____
 Work Phone: _____

Referring Physician

Primary Care Physician

Name: _____
 Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____

Name: _____
 Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____

*****In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be filled our completely**

Primary Insurance

Secondary Insurance

Insurance Company: _____
 Group Name/Number: _____
 Policy Number: _____
 Policy Holder Name: _____
 Copayment Amount: _____

Insurance Company: _____
 Group Name/Number: _____
 Policy Number: _____
 Policy Holder Name: _____
 Copayment Amount: _____

Emergency Contact Person

Name: _____ Phone: _____
 Relationship: _____ Work Phone: _____

I HEREBY ASSIGN TO THE DOCTORS WHOSE NAME APPEARS ABOVE, ALL BENEFITS FOR MEDICAL AND/OR SURGICAL EXPENSE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SAID DOCTORS FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

PARENT OR GUARDIAN SIGNATURE

DATE



Patient History Form

DATE: _____

Patient Name: _____ Age: _____ Date Of Birth: _____

The following information is very important to your health. Please take time to fully and completely fill out these forms. Important decisions are based on this information.

Height: _____ Weight: _____

ALLERGIES: Are you allergic to any medications (including over-the-counter drugs or iodine, tape or latex)?
Circle one: Yes No If yes, please complete the following:

Drug Allergy:	Reaction:	Other Allergy:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL PROBLEMS: Please list all medical problems you have.

MEDICATIONS: Please list all medications (specify dosage and frequency) you are currently taking, including aspirin, over-the-counter medications, vitamins and herbal supplements.

Please list your PAST medications.

OPERATIONS: Please list all operations you have had.

Operation:	Date:	Operation:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY:
Do you use any type of tobacco product? Yes No If yes, how much per day _____
Have you EVER used any type of tobacco product? Yes No Date Quit _____
Do you drink alcohol? Yes No If yes, how often? _____
Do you use illicit drugs? Yes No If yes, please list: _____
For women: Last menstrual period: _____ Number of Pregnancies: _____ Number of Live Births: _____

Physician Signature: _____ **Date:** _____



Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Have you been diagnosed with and/or are you currently having any of the following symptoms?
Please check all that apply.

Neurologic/HEENT:

Have you had any neurological problems? Yes ___ No ___

- Numbness/tingling
- Loss of strength
- Stroke (CVA/TIA)
- Headaches-type _____
- Seizures/epilepsy
- Multiple Sclerosis
- Ear problems
- Eye problems
- Nose/sinus problems
- Throat problems

Musculoskeletal/Skin:

Have you had any muscle/bone problems? Yes ___ No ___

- Back or neck problems/Joint pain
- Loss of sensation
- Rash/skin breakdown
- Arthritis-type _____
- Fractures-type _____
- Osteoporosis

Endocrine:

Have you had any endocrine problems? Yes ___ No ___

- Tired/Sluggish
- Excessive thirst
- Diabetes
- Thyroid problems

Respiratory:

Have you had any breathing problems? Yes ___ No ___

- Wheezing
- Shortness of breath
- Productive or bloody cough
- Asthma
- Emphysema/COPD
- Bronchitis
- Pneumonia
- Sleep apnea
- Pulmonary embolism

Cardiac:

Have you had any heart problems? Yes ___ No ___

- Chest pain (Angina)
- Palpitations/heart racing
- Congestive heart failure
- Heart attack
- High blood pressure
- Pacemaker
- Heart valve
- Rheumatic fever

Blood/Immune System:

Have you had any problems? Yes ___ No ___

- Swollen glands
- Anemia
- Cirrhosis
- DVT/phlebitis/blood clots
- Jaundice
- Lupus
- Bleeding disorders
- Scleroderma

Digestive (Stomach/Bowel):

Have you had any digestive problems Yes ___ No ___

- Abdominal pain
- Nausea/vomiting
- Constipation
- Diarrhea
- Colitis
- Diverticulitis
- Hiatal hernia/reflux disease
- Irritable bowel syndrome
- Ulcers
- Pancreatitis
- Rectal Bleeding/rectal pain
- Change in bowel habits
- Hemorrhoids

Genitourinary/GYN:

Have you had any problems? Yes ___ No ___

- Kidney problems/stones
- Bladder infections
- Kidney failure
- Hernia

Men:

- Prostate problems
- Loss of sexual function

Women:

- Uterine problems
- Ovarian problems
- Infertility
- Bleeding between periods
- Ever taken birth control pills? When: _____
- Complications from childbirth

Constitutional:

Have you had any problems? Yes ___ No ___

- Fever
- Chills
- Weight Loss
- Night sweats

Communicable Diseases:

Have you had any problems? Yes ___ No ___

- AIDS/HIV
- Hepatitis A/B/C
- Sexually transmitted disease
- Tuberculosis

Psychological (Emotional):

Have you had any problems? Yes ___ No ___

- Nervousness
- Anxiety
- Depression
- Other _____

Physician Signature: _____

Date: _____



Patient Name: _____ Date of Birth: _____

Cancer:

Have you ever been diagnosed with cancer? Yes ___ No ___

Type of Cancer:	Treatment:

Other:

Have you had any other medical problems not listed here?

Yes ___ No ___ Please list below:

FAMILY HISTORY:

Please check which, if any, of your blood relatives had any of the following conditions:

Condition	Parent	Siblings/ Children	Other Relatives (Grandparents, Aunts, Uncles, Cousins, etc.)	No Family History	Don't Know
Diabetes					
Heart Disease					
Hypertension					
Gallstones					
Obesity					
Sleep Apnea					
Asthma					
Blood clots					
Cancer					
Stroke					
Kidney Disease					
Bleeding Problems					
Gout					
Allergies					
Dermatitis/Eczema					
High Cholesterol					
Osteoporosis					
Autoimmune Disease					
Psychiatric Illness					

Physician Signature: _____

Date: _____

No changes to history

Physician Signature: _____

Date: _____