Patient Information

Please answer all questions fully

Date: **01/28/2007**

Account Number:

CNY Thoracic Surgery, PC
5100 West Taft Road
Suite 2E
Liverpool, NY 13088
Phone: (315) 634-3399 Fax: (315) 634-3481

Patient

Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone

Mailing Address	City	State	Zipcode	Marital Status
Employer	**City**	**State**	**Zipcode**	**Work Phone**

Responsible Party

Name (Last, First ,MI)	Social Security	Birthdate	Sex	Home Phone

Address	City	State	Zipcode	Marital Status
Employer	**City**	**State**	**Zipcode**	**Work Phone**

Primary Provider	Referring Provider	Referring Address	Phone	Fax

Insurance Information

Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Second Insurance Company	**Subscriber's Name, Birthdate, SSN**	**Relationship**	**Policy Number/Group#**	**Copay**
Third Insurance Company	**Subscriber's Name, Birthdate, SSN**	**Relationship**	**Policy Number/Group#**	**Copay**

Emergency Contact Information

Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Please List Additional Medical Information

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: ______________________________ Date: / /

(Signature of insured or authorized person, patient or parent if minor)

CNY Thoracic Surgery, PC
5100 W. Taft Road
Liverpool, New York 13088
634-3399

Patient's Name: ______________________ DOB: ______________________

Would you like us to leave <u>appointment</u> information on:
(check all that apply)

- Answering machine ☐
- Office voice mail ☐
- With another person at home ☐
- Cell phone voicemail ☐
- Send through the mail? ☐

Would you like us to leave <u>medical</u> information on:
(check all that apply)

- Answering machine ☐
- Office voice mail ☐
- With another person at home ☐
- Cell phone voicemail ☐
- Send through the mail? ☐

Please list anyone you would like us to share your medical information with (other than doctors)

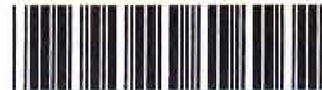
Name (first & last)	Relationship to you
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please note: Staff will not speak to anyone that is not on this list!

ST. JOSEPH'S
Hospital Health Center

301 Prospect Avenue
Syracuse, NY 13203

Please Place Patient Label Here
DO NOT COVER BARCODE



12500

Personal Medical History
Pre-Admission Testing

STAFF USE ONLY	
Ht: ________ Wt: ________kg	Rm #:
O_2: ________ BP: ________	Tech:
P: ____________	RN/C.A.:

Today's Date: ____________

Name: ______________________ **Age:** ________ **Date of Birth:** ____________

Family Doctor: ______________ Doctor's Phone: ________ Last Seen: ________

Specialty Doctor (Heart, Lung, Kidney, etc.) ______________________ Last Seen: ________

Advanced Health Directive: (check what you have AND please bring a COPY to PAT)

☐ **Health Care Proxy** ☐ **Living Wills** ☐ **DNR**

Emergency Contact Person (name, relation, and phone #) ______________________

Past Medical History		**Patient to Complete Past Medical History**	**Staff Use Only ROS**
Constitutional:			
	Weight Stable	☐ Yes ☐ No	ROS
	Fever	☐ Yes ☐ No	ROS
	Chills	☐ Yes ☐ No	ROS
	Night Sweats	☐ Yes ☐ No	ROS
	Unusual Fatigue	☐ Yes ☐ No	ROS
HEENT:			
Eye Problems	Cataracts	☐ Yes ☐ No	ROS
	Glaucoma	☐ Yes ☐ No	ROS
	Macular Degeneration	☐ Yes ☐ No	ROS
	Artificial Eye	☐ Yes ☐ No	
	Glasses	☐ Yes ☐ No	
	Contacts	☐ Yes ☐ No	
	Lens after Cataract Surgery	☐ Yes ☐ No	
Ear Problems	Loss	☐ Yes ☐ No	ROS
	Ringing	☐ Yes ☐ No	ROS
	Hearing Aids ☐ Right ☐ Left	☐ Yes ☐ No	
Arthritis:	Osteo	☐ Yes ☐ No	
	Rheumatoid	☐ Yes ☐ No	
	Gout	☐ Yes ☐ No	

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		Patient to Complete Past Medical History	Staff Use Only ROS
Respiratory:	Asthma	☐ Yes ☐ No	
	Emphysema	☐ Yes ☐ No	
	COPD	☐ Yes ☐ No	
	Sleep Apnea	☐ Yes ☐ No	
	CPAP	☐ Yes ☐ No	
	Oxygen	☐ ____ liters	
	Pneumonia within 6 weeks	☐ Yes ☐ No	
	Bronchitis within 6 weeks	☐ Yes ☐ No	
	Sputum Production	☐ Yes ☐ No	ROS
	Hemoptysis (Cough up Blood)	☐ Yes ☐ No	ROS
	Chronic Cough	☐ Yes ☐ No	ROS
	Shortness of Breath	☐ Yes ☐ No	ROS
Cancer: Where:	____________		
When:	____________		
	Chemotherapy	☐ Yes ☐ No	
	Radiation	☐ Yes ☐ No	
	Port	☐ Yes ☐ No	
Circulation Problems:	Legs	☐ Yes ☐ No	
	Neck	☐ Yes ☐ No	
	Blood Clots	☐ Yes ☐ No	
Endocrine:	Thyroid	☐ Yes ☐ No	ROS
	Diabetes	☐ Yes ☐ No	ROS
	When diagnosed? ____________		
	On Insulin	☐ Yes ☐ No	
	On Insulin Pump	☐ Yes ☐ No	
	Do you test?	☐ Yes ☐ No	
	Average A.M. Blood Sugar		
Heart Disease:	Angina	☐ Yes ☐ No	ROS
	Heart Attack (Myocardial Infarction)	☐ Yes ☐ No	
	Congestive Heart Failure	☐ Yes ☐ No	
	Angioplasty	☐ Yes ☐ No	
	Heart Catheterization	☐ Yes ☐ No	
	Stent	☐ Yes ☐ No	
	Atrial Fibrilation	☐ Yes ☐ No	
	Pacemaker / ICD (Defibrillator)	☐ Yes ☐ No	
	ICD (Defibrilator)	☐ Yes ☐ No	
	Leaky Valve	☐ Yes ☐ No	
	Valve Prolapse	☐ Yes ☐ No	
	High Blood Pressure	☐ Yes ☐ No	ROS
	High Cholesterol	☐ Yes ☐ No	ROS
	Shortness of Breath on Exertion or at rest	☐ Yes ☐ No	ROS
	Chest Pain / Pressure	☐ Yes ☐ No	ROS

Place Patient Label Here

		Patient to Complete Past Medical History	Staff Only ROS
GI:			
Stomach	Reflux	☐ Yes ☐ No	
	Hiatal Hernia	☐ Yes ☐ No	
	Ulcer	☐ Yes ☐ No	
Liver	Cirrhosis	☐ Yes ☐ No	
	Hepatitis	☐ Yes ☐ No	
	Yellowing of Skin	☐ Yes ☐ No	
Bowel	Do you have normal bowel habits?	☐ Yes ☐ No	ROS
	Frequency	____________	
	What do you take to stay regular?	____________	
	Crohns	☐ Yes ☐ No	
	Polyps	☐ Yes ☐ No	
	Diverticulitis	☐ Yes ☐ No	
	Colostomy / Ileostomy	☐ Yes ☐ No	
	Hematochezia (Blood in Stool)	☐ Yes ☐ No	ROS
	Hematemesis (Vomiting Blood)	☐ Yes ☐ No	ROS
	Change in Bowel Habits	☐ Yes ☐ No	ROS
	Last colonoscopy (year) ____________		
GU:			
Kidney	Stones	☐ Yes ☐ No	
	Decreased Function	☐ Yes ☐ No	
	Dialysis	☐ Yes ☐ No	
	If yes, where?	____________	
	When?	____________	
Bladder	Prostate	☐ Yes ☐ No	
	Last prostate exam (year) ____________		
	Stones	☐ Yes ☐ No	
	Growth	☐ Yes ☐ No	
	Do you have normal urinary habits?	☐ Yes ☐ No	
	Incontinence	☐ Yes ☐ No	
	Dropped Bladder	☐ Yes ☐ No	
	Do you have a catheter at this time?	☐ Yes ☐ No	
	Frequency at night	☐ Yes ☐ No	ROS
	Urgency	☐ Yes ☐ No	ROS
	Dysuria (painful or difficult urination)	☐ Yes ☐ No	ROS
GYN:	Last pap test (year) ____________		
	Last mammogram (year) ____________		
	Last menstral period (date) ____________		
Neurologic:	Seizures	☐ Yes ☐ No	
	Tremors	☐ Yes ☐ No	
	CVA (stroke)	☐ Yes ☐ No	ROS
	TIA (mini strokes)	☐ Yes ☐ No	ROS
Extremities / Musculoskeletal:	Muscular Dystrophy	☐ Yes ☐ No	
	Muscle Weakness	☐ Yes ☐ No	ROS
	Numbness	☐ Yes ☐ No	ROS
	Multiple Sclerosis	☐ Yes ☐ No	

Place Patient Label Here

		Patient to Complete **Past Medical History**	Staff Use Only **ROS**
Psychiatric:	Anxiety	☐ Yes ☐ No	
	Depression	☐ Yes ☐ No	
	Panic Attacks	☐ Yes ☐ No	
Skin Problems:	Any Rash or Open Areas	☐ Yes ☐ No	
	Eczema	☐ Yes ☐ No	
	Psoriasis	☐ Yes ☐ No	
	Shingles	☐ Yes ☐ No	
	Cancer	☐ Yes ☐ No	
Steroid Therapy:	Prednisone Use	☐ Yes ☐ No	
Hematologic:	Anemia	☐ Yes ☐ No	ROS
	Bleeding Disorder	☐ Yes ☐ No	ROS

Please List: Serious Injuries, accidents, aneurysms, conditions, Sickle Cell, T.B., other problems

____

____

Past Surgical History (If you have a list of your surgeries, please attach here.)

List **ALL Surgeries** with Approximate Dates:

____

____

____

____

____

____

____

Any PROBLEMS you or your family had with Anesthesia? (Describe) ______________________________

____

Family History (list **SERIOUS** illnesses)

☐ Father: ______________________________

____

☐ Mother: ______________________________

____

☐ Siblings: ______________________________

____

____

☐ Children: ______________________________

____

____

Have you ever been on isolation in the hospital? ☐ Yes ☐ No

Why? ______________________________

When? ______________________________

Place Patient Label Here

Personal Medication History

Name:	Birth Date:
Pharmacies– Name & Phone #s	Doctor(s) (if not previously listed)

Do you have Medication Insurance ☐ **Yes** ☐ **No**

ALLERGIES and Reactions (Be Specific with Reactions) ☐ **No Known Allergies**

Medication Allergies/Reaction:____

Food:__________ Metal:__________ Tapes/Bandaids:________________ Latex:__________

X-ray/Contrast Dye:__________ Iodine Products:__________ Environmental:________________

List all **prescriptions and **over-the-counter** (non-prescription) medications (Example: St. John's Wort, Vitamins). Please include prescription medications taken as needed (Example: Nitroglycerin, pain medication, inhalers, aspirin, eye drops).

Name of Medication	Dose	Directions for use	Reason for Medication	Date stopped

Immunization Record (include date given)

Pneumonia:	Flu:

Keep this list with you.

Bring this list to your doctor visits, the hospital and all medical tests.

✓ Update this form when medications change.

✓ Copies of this form on www.sjhsyr.org

Place Patient Label Here

Substance Abuse/Social History

Do you Smoke now? ☐ Yes ☐ No
Did you smoke in the past? ☐ Yes ☐ No
How many years?____________
When Quit ____________
How many Packs Per Day? ____________

Do you drink alcohol? ☐ Yes ☐ No
What and how much? ____________

Do you use recreational drugs? ☐ Yes ☐ No
What and frequency? ____________

Have you ever been emotionally **ABUSED** by someone close to you? ☐ Yes ☐ No

Have you ever been physically **ABUSED** by someone close to you? ☐ Yes ☐ No

Who ____________ When ____________

Have you experienced any RECENT stress OTHER than upcoming surgery? ☐ Yes ☐ No

Describe ____________

☐ Do you feel you need any counseling at present? ☐ Yes ☐ No

☐ DO you have any CHRONIC (over 6 months) pain? ☐ Yes ☐ No
Where ____________ For how long ____________

Do you have:					
Dentures	☐ Yes	☐ No	Chipped/cracked teeth	☐ Yes	☐ No
Loose Caps/crowns	☐ Yes	☐ No	TMJ (Jaw pain)	☐ Yes	☐ No
Loose Teeth	☐ Yes	☐ No		☐ Yes	☐ No
Braces	☐ Yes	☐ No		☐ Yes	☐ No

Do you have any cultural or religious practices that need to be part of your care? ☐ Yes ☐ No
____

Do you have any religious or other objections to blood products? ☐ Yes ☐ No

Do you have any Discharge Concerns? ☐ Yes ☐ No
____

Do you have any Home Services at this time? ☐ Home Aids ☐ Nurses ☐ Meals on Wheels ☐ Lifeline ☐ Oxygen delivery ☐ Other

Do you have stairs? ☐ Yes ☐ No
Do you live alone? ☐ Yes ☐ No
Who will assist you at home? ____________

This Personal Medical/History has been completed to the best of my knowledge:

Patient's Signature: ____________

If other than patient Signature: ____________ Relation: ____________

Reviewed by (Staff): ____________ Date: ____________