

<b>Patient Information</b>	<b>Referred By:</b>
Last Name: _____ <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Other _____ Sex: Male _____ Female _____	
First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____-_____-_____	
Middle Name: _____ Preferred Name: _____ Primary Language: _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Address: _____ City: _____ County _____ State: _____ Zip: _____	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or OPI <input type="checkbox"/> White	
Student Status: <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> N/A School: _____ Employment: <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> N/A Employer: _____	
Email Address: _____	
Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____	
May we leave a voice message to remind you about appointments at your home or cell phone number? Yes _____ No _____	
May we leave a voice message for normal test results at your home or cell phone number? Yes _____ No _____	
(Pharmacy Name and Phone Number: _____)	
Emergency Contact Name _____	
Relationship _____ Home Phone ( ) _____ Work Phone ( ) _____	
<b>Complete <u>only</u> if you want the Practice to contact you at an address/phone different than you gave above)</b>	
Other Address: _____ City: _____ State: _____ Zip: _____ Other Phone ( ) _____	
_____	

<b>Guarantor/Responsible Person (if different from patient)</b>
Last Name: _____ <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Other _____ Sex: Male _____ Female _____
First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____-_____-_____
Middle: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____
Guarantor Email Address: _____

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Insurance Company: _____	Insurance Company: _____
Policyholder Name: _____	Policyholder Name: _____
Member or Policyholder ID#: _____	Member or Policyholder ID#: _____
Policy Holder Date of Birth: _____	Policy Holder Date of Birth: _____
Insurance Co. Phone Number: (____) _____	Insurance Co. Phone Number: (____) _____
Group # _____	Group # _____
Insurance Co. Address: _____	Insurance Co. Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____

**Ongoing Communication Regarding Your Healthcare**

We may release/discuss your health information with the following people or organizations for the following dates of service, range of time, or event(s):

From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate Authorization to Release Information form must be completed if the information being released is different for these people or organizations listed above.

**Authorization, Assignment of Benefits, and Referral Medical Release**

I allow this Practice to use and release my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Roper St. Francis Healthcare Notice of Information Practices. I have been provided a copy of the Roper St. Francis Healthcare Notice of Information Practices.

I allow the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I request the following restrictions on the use of my information: \_\_\_\_\_

I allow payment made directly to Roper St. Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this practice and my physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

*Office Use Only:*

**SURGICAL ASSOCIATES OF CHARLESTON, P.A.**

**PATIENT HEALTH HISTORY**

**All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.**

**Name** (*Last, First, M.I.*): \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Marital status:**                       Single     Partnered     Married     Separated     Divorced     Widowed

**Referring physician:** \_\_\_\_\_ **Primary care physician:** \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

**Current Chief Complaint:**  
\_\_\_\_\_

**List any medical problems that other doctors have diagnosed**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Operations</b>	<b>Year</b>	<b>Hospital</b>

<b>Other hospitalizations</b>	<b>Year</b>	<b>Hospital</b>

<b>List your prescribed and over-the-counter drugs or vitamins</b>	<b>Strength</b>	<b>Frequency taken</b>

<b>Allergies to medications</b>	<b>Reactions you had</b>

TO COMPLETE TURN OVER

### HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per week?		
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### FAMILY HEALTH HISTORY

	AGE	Significant Health Problems		AGE	Significant Health Problems
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
<b>Siblings</b>	<input type="checkbox"/> M		<b>Grandparents</b>	<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M				
	<input type="checkbox"/> F				

### REVIEW OF SYSTEMS / OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest / Heart	Recent changes in:
<input type="checkbox"/> Head	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Weight
<input type="checkbox"/> Eyes	<input type="checkbox"/> Intestinal / Bowel / GI	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose / Ears / Throat	<input type="checkbox"/> Bladder	<input type="checkbox"/> Neuro - Seizures, etc.
<input type="checkbox"/> Neck / Lymph	<input type="checkbox"/> Psych - Depression	<input type="checkbox"/> Other pain / discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

### WOMEN ONLY

Age at onset of menstruation:	Date of last menstruation:
Period every _____ days	Date of last pap and rectal exam:
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Caesarean?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any history of taking hormone replacement pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any family history of breast disease or breast cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed and Confirmed by Physician** \_\_\_\_\_ **Date** \_\_\_\_\_