NORTH SUBURBAN SURGICAL CONSULTANTS

NORTH SUBURBAN SURGICAL CONSULTANTS PATIENT QUESTIONNAIRE

PATIENT NAME: _____ MARRIED/SINGLE: _____

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY #: _____/_____ /_____

ADDRESS: _____

_____

EMAIL ADDRESS: _____

CELL PHONE #: _____ WK#: _____ HM#: _____

EMPLOYER NAME: _____ EMPLOYER PH. #: _____

SPOUSES EMPLOYER NAME: _____PH #: _____

PRIMARY CARE PHYSICIAN: _____ PH #: _____

IS THIS WHO REFERRED YOU HERE? YES / NO (**please circle one**).

IF NO, PLEASE FILL IN THE ADDRESS AND PHONE # OF WHO REFERRED YOU HERE: _____

_____

_____

CARDIOLOGISTS NAME: _____ PH. #: _____

NAME OF YOUR INSURANCE: _____
WHO IS THE SUBSCRIBER: SELF / SPOUSE / PARENT (**Please circle one**)

NAME OF INSURED: _____ THEIR BIRTHDATE: _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR SERVICES RENDERED TO ME BY NORTH SUBURBAN SURGICAL CONSULTANTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CONTRACT. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY IN ORDER FOR CLAIMS TO BE PAID.

SIGNED: _____Date: _____

Patient's Name: _____

PLEASE CIRCLE AND FILL IN BLANKS OF ANYTHING THAT APPLIES TO YOU

ARE YOU IN GOOD GENERAL HEALTH? YES / NO LARGE WEIGHT GAIN OR LOSS? YES / NO
HEADACHES / MIGRAINES / ARTHRITIS / GOUT / SEIZURES / BLEEDING / MRSA INFECTIONS / DIABETES
HIGH BLOOD PRESSURE / STD'S / HIV / HEPATITIS / PERSONAL HISTORY OF CANCER—WHAT TYPE? _____

_____

EYE ISSUES: CATARACTS / GLAUCOMA / MACULAR DEGENERATION / BLINDNESS / BLURRED OR DOUBLE VISION

EAR NOSE AND THROAT ISSUES: SINUS PROBLEMS / SWOLLEN GLANDS / HEARING LOSS / RINGING IN EARS / SORE THROAT

CARDIOVASCULAR PROBLEMS: CORONARY ARTERY DISEASE / HEART ATTACK / STROKE
IRREGULAR HEARTBEAT / CHEST PAIN / CARDIAC STENT PLACEMENT / SWEELING OF LEGS & ANKES

RESPIRATORY PROBLEMS: ASTHMA / COPD / EMPHYSEMA / SLEEP APNEA / SHORTNESS OF BREATH / WHEEZING

GASTROINTESTINAL PROBLEMS: GERD / CHANGE IN BOWEL MOVEMENTS / VOMITING / DIARRHEA /

CONSTIPATION / ABDOMINAL PAIN / NAUSEA / BLOOD IN STOOL / BLOATING

GENITOURINARY ISSUES: FREQUENT URINATION / STRAINING TO URINATE / WAKING AT NIGHT TO URINATE / INCONTINENCE / BLOOD IN URINE / KIDNEY STONES

MALE:
BPH BENIGN PROSTATE HYPERPLASIA—ENLARGED PROSTATE / HISTORY OF PROSTATE CANCER? _____

FEMALE:
OF PREGNANCIES _____ # OF MISCARRIAGES _____# OF ABORTIONS _____ # LIVE BIRTHS _____

MUSCULOSKELETAL ISSUES: BACK PAIN / ARTHRITIS / JOINT PAIN STIFFNESS & SWELLING / DIFFICULTY WALKING / COLD EXTREMETIES
BREAST PROBLEMS: BREAST PAIN / BREAST DISCHARGE / BREAST LUMP / ABNORMAL MAMMOGRAM / LUMP UNDER ARM
HISTORY OF BREAST CANCER _____ LEFT BREAST / RIGHT BREAST / BILATERAL

NEUROLOGICAL ISSUES: FREQUENT HEADACHES / MIGRAINES / HEAD INJURY / PARALYSIS / DIZZINESS / NUMBNESS—TINGLING
PSYCHIATRIC ISSURES: DEPRESSION/ ANXIETY/SLEEP ISSUES /MEMORY LOSS/ALZHEIMERS/ DEMENTIA / BIPOLAR
ENDOCRINE ISSUES: THYROID DISEASE /EXCESSIVE THIRST /DRY SKIN /GLANDULAR OR HORMONE

ISSUES/HEAT OR COLD INTOLERANCE

ALLERGIES: LATEX/ ADHESIVE /SHELLFISH/ IODINE/ EGGS/CONTRAST DYE/ ASPIRIN / CODEINE / TYLENOL / PENICILLIN
OTHER ALLERGIES: _____

_____

_____

Patient's Name: _____

IS THIS A FOLLOW-UP FROM SURGERY? _____ WHAT TYPE OF SURGERY? _____

_____

WHAT ARE YOU SEEING THE SURGEON FOR TODAY? _____

_____

PLEASE CIRCLE ANY SURGERIES YOU HAVE HAD IN THE PAST: TONSILLECTOMY/ APPENDECTOMY / HYSTERECTOMY/COLON RESECTION/GALLBLADDER REMOVED/WISDOM TEETH/C - SECTION/EXCISION OF SKIN CANCERS/BREAST BIOPSY/LUMPECTOMY/MASTECTOMY/EXCISION OF CYSTS/EXCISION OF BENIGN SKIN LESIONS/HIP REPLACEMENT/KNEE REPLACEMENT/CATARACT SURGERY/PROSTATE SURGERY/EXCISION LIPOMAS

PLEASE LIST ANY OTHER SURGERIES THAT YOU HAVE HAD: _____

_____

_____

_____

DO YOU TAKE MEDICATIONS? PLEASE LIST: _____

_____

_____

_____

SOCIAL HISTORY: ARE YOU/SINGLE/MARRIED/SEPARATED/DIVORCED/WIDOWED **(Please circle what applies)**

OCCUPATION: DO YOU WORK? FULL-TIME/PART-TIME/STUDENT/HOMEMAKER/RETIRED

USE OF ALCOHOL: NEVER/RARELY/SOCIALLY/DAILY # OF DRINKS PER WEEK: _____

USE OF TOBACCO: NEVER/FORMER SMOKER WHEN DID YOU QUIT?_____

CURRENT SMOKER: HOW MANY PACKS/DAY? _____

USE OF RECREATIONAL DRUGS: NEVER/YES IF YES, TYPE & FREQUENCY: _____

_____

DO YOU HAVE EXCESSIVE EXPOSURE TO: DUST/CHEMICALS/SMOKE/OTHER

PAST FAMILY HISTORY: (Please list family medical history)

FATHER: _____

MOTHER: _____

MATERNAL GRANDMOTHER: _____

MATERNAL GRANDFATHER: _____

PATERNAL GRANDMOTHER: _____

PATERNAL GRANDFATHER: _____

OTHER: _____

Patient's Name: _____

NOTICE OF PRIVACY PRACTICES

This practice is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

We may disclose your health information for the sole purpose of:

TREATMENT: we may disclose you heath care information to other health care professionals for the purpose of treatment, payment or health care operations.

PAYMENT: We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations. We may also disclose this information to Workers Compensation if necessary in order to comply with the law.

EMERGENCIES: We may disclose your health information to a family member or the person responsible for your care, about you medical condition in the event of an emergency or upon your death. We may also disclose your health information to coroners or medical examiners if necessary.

JUDICIAL AND ADMINISTRATIVE: We may disclose your health information for any administrative or judicial proceeding.

RESEARCH: We may disclose your health information for medical purposes to researchers approved by an institutional board.

PUBLIC HEALTH: We may disclose your health information to public health authorities as required by law.

CHANGE OF OWNERSHIP: In the event that this practice is sold or merged, your record will become the property of the new owner.

COMMUNICATION WITH FAMILY: Unless you object, we may disclose to a member of your family, relative, or close friend, or other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such discloser, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care.

You have the right to request restrictions on this disclosure of your health information, you may inspect and copy your health information. You may request a copy of this notice. You also have the right to accounting of disclosures made by this practice.

I have read this privacy notice and understand my rights.

Patient Name: _____ Patient signature: _____

(**Please print**)

Date: _____

Patient's Name: _____

I authorize North Suburban Surgical Consultants and staff to leave medical information pertaining to my care by the methods below. I will assume responsibility to notify them whenever this information changes.

Home Telephone: _____ yes/no

Answering Machine: _____ yes/no

Work/Voicemail: _____ yes/no

Cell Phone: _____ yes/no

Please list name of authorized people:

Spouse: _____ Phone #: (___)_____

Parent: _____ Phone #: (___)_____

Other designated people (boyfriend, girlfriend, fiancé, sibling, etc.)

Name: _____ Relationship: _____Phone #: (___)_____

Name: _____ Relationship: _____Phone #: (___)_____

Patient/Guardian Signature: _____

Date: _____