York Surgical Associates, P.C.
2114 N. Lincoln Ave., Suite B
York, NE 68467
Phone:402-362-4339
Fax:402-362-7743

PATIENT INFORMATION Date of Visit:_______________

Patient Name *(Last, First)*:______________________________________SSN:___________________________________

Birthdate:_____/______/______ Gender: Age:_________ Ethnicity:

Race:

Address:_______________________________________City:_______________State:________Zip:________________

Marital Status: Retired:

Spouse's name:____________________Parent/Guardian Name ***if*** minor:____

Home Phone:_______________Cell:_______________E-mail Address:____

Insurance Carrier and ID#:____

If you receive disability benefits, please list your disability:____

Employed by:____________________________Phone#:_____________How long:____Position:___________________

Work Comp: Date of Work Related Incident:___________________________

Pharmacy(name and City):____

Family Doctor:_________________________________Referring Doctor:____

Billing Information ***if*** Different (Name/Address):____

Emergency Contact Name (***not living in the same house***):____

Emergency Contact Phone#:_______________________Relationship:____

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Patient Name *(Last, First)*:__________________________Birthdate:_____/______/______Today's date:____/_____/_____

ALLERGIES TO MEDICATIONS

Drug Name **Rection** ***(check those that apply, please select localized or generalized or hives)*** **Severity**

_______________ _____Rash _____Vomiting/Diarrhea ____Other(please list)

_______________ _____Rash _____Vomiting/Diarrhea ____Other(please list)

_______________ _____Rash _____Vomiting/Diarrhea ____Other(please list)

LATEX ALLERGY*(circle one)*: **Yes/No**

CURRENT MEDICATIONS - LIST ALL *PRESCRIBED* AND *OVER THE COUNTER*

Note: Name and dosage *Example:* Zyrtec 10mg daily

____

____

____

____

____

PAST MEDICAL HISTORY ***(Please select all past or present problems)***

Have you ever had a colonoscopy? : Date (year) of last colonoscopy:__________________________

Have you ever been diagnosed with cancer? : Age at diagnosis:________________________________

If Yes, please list types of cancer:____

Any other current or past medical problems not listed:____________________________________

SOCIAL HISTORY

Do you use tobacco?:____________What kind?:____________Daily amount?:_________________How many years?:_______

If no, have you ever used tobacco in the past?:_____________________What year did you quit?:________________________

Do you drink alcohol?:___________What kind?:____________Daily amount?:_________________How many years?:_______

Do you use/abuse other substances?:_______What kind?:____________Daily amount?:_________How many years?:_______

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SURGERIES/HOSPITALIZATIONS AND ANESTHESIA REACTIONS

Have you ever had surgery with general anesthesia or sedation? :

If "Yes", did you have a reaction to anesthesia? : Type of reaction:______________________________

Please list any surgeries you have had:____Year:__________

____Year:__________

____Year:__________

Please list previous hospitalizations:____

____

____

FAMILY HISTORY (*Please circle any diseases that run in blood relatives)*

Have any relatives been diagnosed with cancer? :

If Yes, please list types of cancer and how that person is/was related to you:____

____

Any other diseases not listed that run in your family (blood relatives)?:____

OB/GYN INFORMATION

Age at 1st period:________ # of pregnancies:_______ Your age at the time of your first pregnancy:_______ Did you breast feed?: Y/N

# of miscarriages:______ # of abortions:____ Last menstrual period:___________ Age at menopause/hysterectomy:_________________

Date of last Mammogram:________Date of last PAP smear or pelvic exam:______# of children living and their ages:_______________

MISCELLANEOUS INFORMATION

Any previous X-ray therapy (*list type and reason, e.g. radiation for cancer*):____

Have you ever taken cortisone type drugs or steroids *(list type and reason*):____

Have you ever received a blood transfusion *(list when and why*):____

Your weight dressed: ______________ How long at this weight?:____

Please describe the reason you are here:____

____

____