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: M / F Age:_____Ethnicity (circle one): Hispanic/Non-Hispanic

Race (circle one):

Caucasian Asian African American Native American Indian Alaskan Native Pacific Islander Other

Address:_____City:_____State:_____Zip:_____

Marital Status: Single/married/widow/widower/divorced Retired (circle one): Yes No

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 (circle one): Yes No 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:_____

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

Patient Name *(Last, First)*:_____ **Birthdate:**____/____/____ **Today's date:**____/____/____

ALLERGIES TO MEDICATIONS

Drug Name	**Reaction (*check those that apply, please circle localized or generalized or hives*)**	**Severity**
_____	____Rash (localized/generalized/hives) ____Vomiting/Diarrhea ____Other(please list)	mild/mod/severe
_____	____Rash (localized/generalized/hives) ____Vomiting/Diarrhea ____Other(please list)	mild/mod/severe
_____	____Rash (localized/generalized/hives) ____Vomiting/Diarrhea ____Other(please list)	mild/mod/severe

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 circle all past or present problems)*

Asthma	Bowel problems	HIV	Kidney failure	Hepatitis
Bleeding tendencies	Constipation	Heart attack	Kidney stones	Rheumatic fever
Blood clots in veins/lungs	Diarrhea	Congestive heart failure	Stroke	Lumps in breast/groin/neck
Blood in Urine	Diabetes	High Blood pressure	Phlebitis	Shortness of breath
Dark, tarry stools	Epilepsy	Inherited abnormalities	Pneumonia	Thyroid problems
Bright red blood in stools	Gallbladder problems	Nausea/Vomiting	Ulcers	Heartburn
High Cholesterol				

Have you ever had a colonoscopy? (*circle one*): Yes/No Date (year) of last colonoscopy:_____

Have you ever been diagnosed with cancer? (*circle one*): Yes/No 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?:_____

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

Patient Name *(Last, First)*:_____ **Birthdate:**____/____/____ **Today's date:**____/____/____

SURGERIES/HOSPITALIZATIONS AND ANESTHESIA REACTIONS

Have you ever had surgery with general anesthesia or sedation? (*circle one)*: Yes/No

If "Yes", did you have a reaction to anesthesia? (*circle one*): Yes/No 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)*

Asthma	Bowel problems	HIV	Kidney failure	Hepatitis
Bleeding tendencies	Constipation	Heart attack	Kidney stones	Rheumatic fever
Blood clots in veins/lungs	Diarrhea	Congestive heart failure	Stroke	Lumps in breast/groin/neck
Blood in Urine	Diabetes	High Blood pressure	Phlebitis	Shortness of breath
Dark, tarry stools	Epilepsy	Inherited abnormalities	Pneumonia	Thyroid problems
Bright red blood in stools	Gallbladder problems	Nausea/Vomiting	Ulcers	Heartburn
High Cholesterol				

Have any relatives been diagnosed with cancer? (*circle one*): Yes/No

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:_____

_____

_____