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	**Reaction**	***(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 check all past or present problems that apply - check boxes to left of each line)***

__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? : 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 check any diseases that run in blood relatives - check boxes to left of each line)***

__Asthma	__Bowel problems	__HIV	__Kidney failure	__Hepatitis
__Bleeding tendencies	__Constipation	__Heart attack	__Kidney stones	__Rheumatic fever
__Blood clots in veins	__Diarrhea	__Congestive heart failure	__Stroke	__Lumps in breast/groin/neck
__Blood in urine	__Diabetes	__High blood pressure	__Phlebitis	__Shortness of breath
__Bright red blood in stools	__Epilepsy	__Inherited abnormalities	__Pneumonia	__Thyroid problems
__Dark, tarry stools	__Gallbladder problems	__Nausea/Vomiting	__Ulcers	__Heartburn
__High cholesterol				

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?:

# 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:_____
(MM-YY)

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:_____

_____

_____