BHS Surgery
SURGICAL ASSOCIATES

INITIAL PATIENT HEALTH ASSESSMENT QUESTIONNAIRE

NAME: ____ **Date:**_______________________

Date of Birth: _______________________ **Age:** ______________

Phone: _____________________________ **Cell:** ___________________________________

Reason for today's Visit?

Medical History (list those conditions you are presently being treated for or have been treated for in the past):

Surgeries (List all operations you have had): ____

____

Family History:	**Living**	**Age**	**Medical Problems**
Mother	Y/N	___	_______________________________________
Father	Y/N	___	_______________________________________
Brothers	Y/N	___	_______________________________________
Sisters	Y/N	___	_______________________________________
Children	Y/N	___	_______________________________________

Any other family history of:

Bleeding Disorder_____________
Heart attack___________
Kidney Disease_____________
Cancer_______________________
Heart Disease__________
Lung Disease_______________
Cholesterol Problems__________
Hypertension__________
Seizures___________________
Diabetes____________________

Social History

Do you smoke: Yes__ No__ How many packs per day? _______________

Have you ever smoked? Yes__ No__

How long did you smoke? ________ How much did you smoke? ________ When did you quit?________

Do you chew tobacco/Snuff? Yes__ No __

Do you use illicit drugs? Yes __ No __

Have you ever been treated for Substance abuse? Yes__ No__

Do you drink Alcohol? Yes __ No __ How many drinks per week? __________

Do you drink Caffeine? (Coffee, Tea, Pop) Yes __ No __ How many cups per day? _____________

What is your current occupation? ____

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Please Print

List All Present Medication and Dosage:

___________________ ________________________ ____________________
___________________ ________________________ ____________________
___________________ ________________________ ____________________
___________________ ________________________ ____________________
___________________ _______________________ ____________________

List All Allergies:

___________________ ________________________ ____________________
___________________ ________________________ ____________________
___________________ ________________________ ____________________

Preferred Pharmacy: __________________________________ **Phone No.:**______________________

Family Doctor: ____

Referring Doctor: ____

Emergency Contact:

Name: ____

Relationship: ____

Phone: ____

BHS Surgical Associates
Meng-g M. Lee, MD Tony M. Maalouf, MD Victor E. Nieto, MD Andrew J. Szabo, DO
Megan M. Morando, PA-C Renee D. Pentz, PA-C Emily M Woodward, PA-C
BHS Crossroads Campus 129 Oneida Valley Road Suite 111 Butler, Pennsylvania 16001

Phone: **724-431-4190** Fax: **724-431-4192**

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Please Print

System Review (In general, any problems with any of the following- please check)

General: Fever____ Chills____ Sweats____ Anorexia____ Fatigue____ Weight Loss____ Weight Gain____

Eyes: Blurry____ Double Vision____ Irritation____ Discharge____ Vision Loss____ Eye Pain____ Sensitive to light ___

Ear/Nose/Throat: Earache____ Ear Discharge____ Ear Ringing____ Decreased Hearing____ Nasal Congestion____ Nose Bleeds____ Sore Throat____ Hoarseness_____ Difficulty Swallowing ____

Heart: Chest Pain____ Chest pain with Exertion____ Fainting____ Swelling In limbs____ PND____ Needs Propped up while in bed____

Lungs: Breathing Problems w/Exertion____ Excessive Sputum____ Wheezing____ Frequent Cough____ Coughing up Blood____

Intestinal: Abdominal Pain____ Change in bowel habits____ Constipation____ Diarrhea____ Vomiting____ Nausea____ Jaundice____ black tarry stools____ Blood in Stool____

Urinary: Frequent Urination____ Discharge____ Genital Sores____ Painful Urination____ Blood in Urine____ Incontinence____ Impotence____ Urinary Hesitancy____ Night Urinations____ Decreased Libido____

Skeletal: Arthritis____ Back Pain____ Muscle Cramps____ Joint Pain____ Muscle Weakness____ Stiffness____

Skin: Suspicious Lesions____ Rash____ Itching____ Dryness____

Neurologic: Weakness____ Seizures____ Fainting____ Tremors____ Vertigo____ Sensory Loss____ Numbness/Tingling____

Psychiatric: Depression____ Anxiety____ Memory Loss____ Mental Disturbance____ Suicidal Thoughts____ Hallucinations____ Paranoia____

Endocrine: Cold Intolerance____ Heat Intolerance____ Weight Change____ Excessive Hunger____ Excessive Urination____

Heme/ Lymphatic: Abnormal Bruising____ Bleeding____ Enlarged Lymph nodes____

BUTLER MEDICAL PROVIDERS
PHYSICIAN DIVISION

Notice and Acknowledgment

I acknowledge that the office has a new Notice of Privacy Practices and the notice has been made available to me.

Patient Name____
(Print Name)

Date of Birth_____________________

_________________________________ _________________
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

Notice & Acknowledgment:

BUTLER MEDICAL PROVIDERS
PHYSICIAN DIVISION

PATIENT REQUEST FOR DISCLOSING VERBAL INFORMATION

PATIENT NAME:___________________________________ DATE OF BIRTH:_________________

I do ☐/do not☐ consent for detailed messages to be left on my voicemail.

Phone:_______________________________

Please list any person(s) whom you allow this office to discuss your medical care with (such as parents/spouse/ children,etc.)

Name:______________________________ Relationship:______________ Phone________________

Name:______________________________ Relationship:______________ Phone________________

Name_______________________________Relationship:_______________ Phone________________

Name:______________________________Relationship:_______________ Phone _______________

Special Instructions or
Limitations:____

____

As an extra measure of security, before any member of our office staff will discuss any aspect of your care with you or any person listed above, you or that person must know the unique password that you create with this office. Please choose any word that is easy to remember for you and the listed members. For example: pet's name, favorite vacation, favorite food, favorite color, etc. <u>Be sure to notify all person's listed above of your password</u>.

Secure Password:____

Password Hint:____

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office in writing if you wish to alter the designations above. With my signature, I am aware that BMP Physician Division encompasses many different Physician Specialties within Butler Health System. Any of those offices may have access to my medical records.

____ _________________

Signature of Patient/Legal Representative: Date/Time:

Relationship to Patient:____

This authorization hereby revokes any previous authorizations.

To revoke this authorization, please send a written request to our office.