OREGON ADVANCED SURGERY

PATIENT INFORMATION

Today's Date:_____ Referring Physician/ Phone #:_____
Primary Care Physician/ Phone #:_____
Last Name:_____ First Name:_____ Middle Initial_____
Address:_____
City:_____ State:_____ Zip Code:_____ Sex: M_____ F _____
Email:_____Primary Language:_____ Ethnicity:_____ Race:_____
Age:_____ DOB:_____ Home Ph:_____ Cell Ph:_____
Marital Status: Married _____ Single _____ Divorced _____ Domestic Partner _____Widowed _____
Patient's Employer:_____
Employer's Address:_____
City:_____ State:_____ Zip Code:_____ Occupation:_____
Emergency Contact:_____Relationship:_____Phone:_____

Primary Insurance Information

Insurance Name:_____ Co-Payment:$_____
Policy Holder/Subscriber Name:_____ Relationship:_____ DOB:_____
Insurance Address:_____
City:_____ State:_____ Zip Code:_____
Insurance ID # or Social Security #:_____Group/Plan #:_____

Secondary Insurance Information

Insurance Name:_____ Co-Payment:$_____
Policy Holder/Subscriber Name:_____ Relationship:_____ DOB:_____
Insurance Address:_____
City:_____ State:_____ Zip Code:_____
Insurance ID # or Social Security #:_____Group/Plan #:_____

Responsible Party/ Responsible for Payment: Self_____ Spouse_____ Parent_____ Other_____
Name:_____ DOB:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Responsible Party's Employer:_____ Employer Phone Number:_____
Employer Address:_____

I understand that I am personally responsible for all charges by my physician whether or not paid for by insurance and guarantee payment of the bill. I authorize payment of the medical benefits directly to the physician. I also authorize release of medical or other information to my insurance company

_____

Signature Required **Date**

Daniel Tseng, MD FACS **General Surgeon** | Emma Patterson, MD FRCSC, FACS **Bariatric Surgeon**

1040 NW 22nd Ave, Ste 500 Portland, OR 97210 | 9155 SW Barnes Rd, Ste 318 Portland, OR 97225
P: 503.731.3700 F: 971.634.2087 www.orsurg.com

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PATIENT HOME MEDICATION RECORD

Please complete this form as accurately as possible. List all **prescription** medications, as well as **over-the-counter** medications such **as vitamins, pain medication, herbals**, including those taken "as needed". This information is required by the hospital prior to your surgical date. Failure to complete this form may result in the cancellation of your surgical procedure.

NAME:_____**DOB**_____

List all medication allergies here:_____

_____

List all medications currently taking here:

	TYPE	DOSAGE	AMOUNT	REASON
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

The above information is true, complete, and correct to the best of my belief.

_____ _____

(Signature of Patient or Guardian) (Date)

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REVIEW OF SYSTEMS
PLEASE CIRCLE ALL THAT APPLY

Name:_____ **Date:**_____ **DOB:**_____

General: Fever, chills, sweats, fatigue, feeling of general discomfort, weight loss, loss of appetite, weight gain, sleep disorder, anorexia

Eyes: Blurring, double vision, irritation, discharge, vision loss, eye pain, light sensitivity

Ear/Nose/Throat: Ear pain or discharge, ringing, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, difficulty swallowing

Cardiovascular: Chest Pains, irregular heartbeats, fainting, heart murmur, heart attack, shortness of breath, pacemaker, swelling of feet or ankles, high blood pressure, high cholesterol

Respiratory: Cough, shortness of breath, excessive mucus, coughing up blood, wheezing, sleep apnea

GI: Nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, black stools, blood in stools, jaundice, hernia, ulcer, GERD, gas/bloating, difficulty swallowing, reflux

GU for Male: Painful urination, blood in urine, discharge, urinary frequency, urinary hesitancy, nocturia, incontinence, erectile dysfunction

GU for Female: vaginal discharge, incontinence, painful urination, blood in urine, urinary frequency, abnormal vaginal bleeding, pelvic pain, pregnancy

MS: back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis, leg pain

Derm: rash, itching, dryness, skin cancer, un-healing ulcers, hives

Neuro: Weakness, numbness, seizures, fainting, tremors, vertigo, stroke

Psych: Anxiety, memory loss, confusion, depression, mental disturbance, suicidal thoughts, hallucinations, paranoia

Endocrine: Cold intolerance, heat intolerance, excessive thirst, excessive appetite, excessive urination, weight change, diabetes, thyroid problems

Heme/Lymphatic: Abnormal bruising, bleeding, enlarged lymph nodes, blood thinner use

Allergic/Immunologic: Hives, hay fever, persistent infection, HIV exposure, AIDS, MRSA

Oncologic: Radiation/Chemotherapy

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MESSAGE CONSENT FORM

Please read the following carefully and initial what types of contact you agree to:

- It is okay to leave a detailed message at my home _____
- It is okay to leave a detailed message with the following people: _____

  List name(s): _____
  _____
  _____

- It is okay to call me at work with results _____
- It is okay to email me with medical and appointment information _____

  Email address:_____

My preferred method of contact is:

Home phone _____
Cell _____
Email _____

_____ _____
Signature Date

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MEDICAL INFORMATION FORM

PATIENT NAME_____ **DATE**_____

AGE___ ☐ **MALE** ☐ **FEMALE** **REFERED BY**_____ **PCP**_____

HAS THE PATIENT PREVIOUSLY BEEN SEEN BY A DOCTOR AT SURGICAL ASSOCIATES?

YES__NO__ WHO_____**M.D.**

CHIEF COMPLAINT

1._____

2._____

3._____

PAST MEDICAL HISTORY AND SURGICAL HISTORY

OPERATIONS	**HOSPITAL & CITY**	**DATE**
1.		
2.		
3.		
4.		

HOSPITALIZATIONS

REASON	**HOSPITAL & CITY**	**DATE**
1.		
2.		
3.		

MEDICAL CONDITIONS **FOR MEDICATIONS & ALLERGIES (please see other form)**

Please mark all that apply. Give Date and Details when possible

☐ **Heart Attack**	☐ **Lung Disease/Asthma**	☐ **GERD**
☐ **Irregular heart rate**	☐ **Prior Pneumonia**	☐ **Prolonged Bleeding**
☐ **Chest Pain (Angina)**	☐ **Kidney Disease**	☐ **Arthritis**
☐ **High Blood Pressure**	☐ **Intestinal/Rectal Bleeding**	☐ **Seizures**
☐ **Diabetes**	☐ **Hepatitis/Jaundice**	☐ **Alcoholism**

Other illnesses_____

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Check if you have ever had any of the following

☐ **COLONOSCOPY** **DATE**_____ **RESULTS**_____ ☐ **EGD** **DATE**_____

☐ **MAMMOGRAM** **DATE**_____ **RESULTS**_____ **RESULTS** _____

PERSONAL HISTORY

Place of Birth_____

Children **Yes/No** **Ages**_____

Tobacco ☐ **Never** ☐ **None Now** ☐ **Yes Now** **How Long**_____ **How Many Per Day**_____

Alcoholic Beverages ☐ **Never** ☐ **Seldom** ☐ **Frequently** **Amount**_____

Drug Abuse ☐ **Never** ☐ **In the Past** ☐ **Now** **Types of drugs**_____

FAMILY HISTORY

Please check if any blood relatives have a history of any of the following. If so, please note which family member and at what age of onset.

Family History	Family Member	Age of Onset
Alcoholism		
Asthma		
Blood Diseases		
Breast Cancer		
Colon Cancer		
Diabetes		
Esophageal Cancer		
Gastric Cancer		
Heart Disease		
High Blood Pressure		
Lung Cancer		
Obscure Diseases		
Ovarian Cancer		
Pancreatic Cancer		
Prostate Cancer		
Psychiatric Disease		
Thyroid Cancer		

☐ **Family History Unknown**

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