Comprehensive Surgical Group of Northeast Ohio

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Patient Information

Name_____

Address_____City_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

D.O.B.____/____/____ Age_____ Sex_____ SS#_____

Married_____ Single_____ Separated_____ Divorced_____ Widowed_____

Race_____ Hispanic_____ Non-Hispanic_____ Language_____

Employer Name_____ Occupation_____

Emergency Contact_____ Phone Number_____

Spouse/Parent Information

Name_____ SS#_____ D.O.B _____/_____/_____

Phone #_____

Primary Insurance Information

Primary Insurance Company_____

Policy ID #_____ Group Number_____

Name of Insured_____ SS#_____

D.O.B.____/____/____ Phone #_____Employer_____

Secondary Insurance_____ ID#_____

Name of Insured_____ D.O.B.____/____/____

Primary Care Physician_____ Referred By_____

Reason for Office Visit_____

How long have you had this problem?_____

Local Pharmacy_____ Mail Order_____

Medical Allergies and Reactions:

_____

_____

_____

_____

Current Medications: For Treatment of:

_____

_____

_____

_____

_____

_____

Past Surgical History

Operations	Where	When	Surgeon

Date of Last Mammogram:_____Date of Last Colonoscopy:_____

Family History of Medical Conditions

Father_____Living_____Deceased_____

Mother_____Living_____Deceased_____

Social History: Please check all that apply to you.

Smoker: Current____ Heavy____ Former____ Never____

Alcohol: Yes____ No____ Never____ If yes, how much per day____ per week____ social____

Drug/Substance Abuse: Yes____ No____ If yes, type_____How often_____

Caffeine Drinks: Yes____ No____ If yes, how much per day?_____

Medical History

Weight Gain____ Anorexia____ Anxiety____ Weight Loss____ Fatigue____ Night Sweats____

Ear Symptoms_____Nose_____Mouth or Throat_____

Hypertension_____ Heart_____ Respiratory_____

Hepatitis_____ Gastrointestinal Problems_____ Liver Disease_____

Neurologic_____ Stroke_____ Depression_____

Kidney Disease_____ Diabetes_____ Thyroid_____

Blood Disease_____ Anemia_____ Transfusions_____

Autoimmune Disease: Yes_____ No_____

Your appointment is scheduled for_____at_____

Please fill out forms and return in the self-addressed stamped envelope.