Patient Registration Form

University Surgical Associates
Exceptional surgeons. Compassionate care.

Visit Information

Type of Visit ☐ Personal ☐ Worker's Comp ☐ Other Accident ☐ MVA/Auto Accident

Referral Source ☐ Physician ☐ Relative/Friend ☐ Online ☐ Advertisement ☐ Yellow Pages ☐ Other

Referring Physician _____ Street Address _____

City _____ State _____ Zip _____ Office Phone _____

Patient Information

Name (First, Middle, Last) _____ Date of Birth _____ SS# _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip _____ Employer's Phone _____

Spouse Information

Name (First, Middle, Last) _____ Date of Birth _____ SS# _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip _____ Employer's Phone _____

Emergency Contact

Name (First, Middle, Last) _____ Relationship to Patient _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip _____ Employer's Phone _____

Billing Information

Patient Name:

Billing Name | Date of Birth | SS#

Street Address | Apt. #

City | State | Zip | Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Insurance Information

Primary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Primary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Secondary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Secondary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Reason for Visit

Patient Name:

Patient Name (First, Middle, Last)

Referring Physician

Current condition/complaint

OFFICE USE ONLY

(RUE) BP

Height

(LUE) BP

Weight

Heart Rate

Temp.

Resp. Rate

Allergies

Reactions

History of present illness

Previous Hospital Admissions/Surgeries/Serious Injuries

Current Medications

Patient Name:

Patient Medical History

Diabetes	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart issues	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Bleeding tendancy	☐ Yes	☐ No
Recent infections	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Hepatits	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Family history of polyps	☐ Yes	☐ No
Family history of cancer	☐ Yes	☐ No
Family history of breast cancer	☐ Yes	☐ No

Patient Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco ☐ Never ☐ Previously, but quit Current packs/day

Use of Drugs ☐ Never Type/Frequency

Family Medical History

	Age	Diseases	Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

Review of Systems

Patient Name: _____

Please check appropriate answer

CONSTITUTIONAL SYSTEM

Good general health	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

EYES

Eye disease or injury	☐ Yes	☐ No
Wear glasses/contact lenses	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

EARS/NOSE/THROAT

Hearing loss/ringing	☐ Yes	☐ No
Chronic sinus problems	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Bad breath or bad taste	☐ Yes	☐ No
Sore throat/voice change	☐ Yes	☐ No

CARDIOVASCULAR

Heart problems	☐ Yes	☐ No
Chest pain or angina	☐ Yes	☐ No
Palpitation	☐ Yes	☐ No
Shortness of breath walking	☐ Yes	☐ No
Shortness of breath lying	☐ Yes	☐ No
Swelling of feet/ankles/hands	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No

RESPIRATORY

Chronic coughing	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No

MUSCULOSKELETAL

Joint pain/stiffness/swelling	☐ Yes	☐ No
Weakness in muscles/joints	☐ Yes	☐ No
Muscle pain or cramps	☐ Yes	☐ No
Cold extremities	☐ Yes	☐ No
Difficulty walking	☐ Yes	☐ No

GASTROINTESTINAL

Loss of appetite	☐ Yes	☐ No
Change in bowel movements	☐ Yes	☐ No
Painful bowel movements	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Rectal bleeding/blood in stool	☐ Yes	☐ No
Abdominal pain/heartburn	☐ Yes	☐ No
Peptic ulcer	☐ Yes	☐ No
Unable to restrain stools	☐ Yes	☐ No
Colon cancer	☐ Yes	☐ No
Polyps	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No

Have you ever had the following tests:

Colonoscopy	☐ Yes	☐ No
Barium enima	☐ Yes	☐ No
Flexible sigmoidoscopy	☐ Yes	☐ No

BLOOD AND LYMPH

Slow to heal after cuts	☐ Yes	☐ No
Bleeding/bruising tendancy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Blood clots	☐ Yes	☐ No
Past transfusion	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No

URINARY AND REPRODUCTIVE

Frequent urination	☐ Yes	☐ No
Burning/painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Unable to restrain/dribbling	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Male- testicle pain	☐ Yes	☐ No
Female- pain with periods	☐ Yes	☐ No
Female- irregular periods	☐ Yes	☐ No
Female- vaginal discharge	☐ Yes	☐ No
Female- breast feed	☐ Yes	☐ No
Female- hysterectomy	☐ Yes	☐ No
Female- ovaries removed	☐ Yes	☐ No
Female- birth control	☐ Yes	☐ No
Female- age started period		

Urinary/reproductive, continued

Female- last menstral period (date)	
Female- # of pregnancies	
Female- # of miscarriages	
Female- Age of first pregnancy	
Female- # of children	
Female- date of last pap smear	

SKIN AND BREAST

Rash or itching	☐ Yes	☐ No
Breast pain or soreness	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No
Had recent mammogram	☐ Yes	☐ No
Any previous breast surgery	☐ Yes	☐ No

NEUROLOGICAL

Frequent headaches	☐ Yes	☐ No
Light headed or dizzy	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Head injury	☐ Yes	☐ No

ENDOCRINE

Gland/hormone problem	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Excessive thirst/urination	☐ Yes	☐ No
Heat or cold intolerance	☐ Yes	☐ No
Skin becoming dryer	☐ Yes	☐ No

PSYCHIATRIC

Memory loss/confusion	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Problems sleeping	☐ Yes	☐ No