PATIENT'S INFORMATION

Last Name First Name Middle Name	Sex ☐ M ☐ F	Age	Birthdate ____/____/_____
Patient's Address			
City State Zip code			

Home Phone ( )	Mobile Phone ( )	Social Security Number
Marital Status (Please Circle One) Single Married Divorced Separated Widowed		Email Address
Occupation		Language Spoken
Employer's Name		Office Phone ( )

Primary Care Physician	Office Phone ( )
Referring Physician	Office Phone ( )

PERSONAL INSURANCE INFORMATION - PRIMARY

Subscriber's Name	Patient's Relationship to Subscriber
Insurance	ID Number

PERSONAL INSURANCE INFORMATION - SECONDARY

Subscriber's Name	Patient's Relationship to Subscriber
Insurance	ID Number

NAME OF RELATIVE OR FRIEND – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

Name/Relationship	Phone ( )

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize The Surgery Group of Los Angeles to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits.

Patient's Signature	Date

COMPREHENSIVE PATIENT HISTORY

Patient's Name:	Date:

What is the main reason for your visit today? (Please Describe)

_____

_____

ALLERGIES TO FOOD/MEDICATION (INCLUDING TYPE OF REACTION)

1. _____ 3. _____
2. _____ 4. _____

MEDICAL HISTORY (Please indicate if you have or have had any of the following by encircling Yes or No, followed by a brief explanation, including dates.)

High Blood Pressure	YES	NO	_____
High Cholesterol	YES	NO	_____
Diabetes	YES	NO	_____
Cardiac Disease	YES	NO	_____
Strokes	YES	NO	_____
Seizure Disorders	YES	NO	_____
Migraines	YES	NO	_____
Thyroid Disease	YES	NO	_____
Lung Disease (Type)	YES	NO	_____
Liver Disease/Hepatitis	YES	NO	_____
Kidney Disease	YES	NO	_____
Cancer	YES	NO	_____
Bleeding Disorder/Tendency	YES	NO	_____
Gastrointestinal Disorder	YES	NO	_____
Depression/Anxiety	YES	NO	_____
Other Conditions (Specify)	YES	NO	_____

(Women) Number of Pregnancies: _____ Vaginal Deliveries: _____ C-sections: _____

SURGICAL HISTORY (please list all operations that you have had and when they were done.)

_____

_____

_____

_____

FAMILY HISTORY (Please list any family history of high blood pressure, high cholesterol, diabetes, strokes, seizures, migraines or any other diseases)

_____

_____

_____

_____

LABORATORY OR DIAGNOSTIC IMAGING (Please list any recent laboratory or related imaging done in the last 3 years)

_____

_____

MEDICATIONS (Please fill in attached sheet)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY USING

This list should include prescription medications, over the counter medications (Tylenol, Aspirin, Advil, etc.) and any vitamins or herbs. Try to be specific as possible about the amount and frequency of use of these medications.

Medication Name	Dose (mg or # of pills)	Doses per Day	Days per Week

PLEASE LIST ALL PREVIOUS MEDICATIONS YOU'VE TAKEN IN THE PAST

This is a list of all medications that you have taken in the past for your symptoms including prescription medications, over the counter medications. Please indicate why you are no longer taking this medication.

Medication Name	Reason for Discontinuing