St Lawrence Surgery
305 Main Street
Ogdensburg, NY 13669
(315) 393-2611

Date: _____

Name: _____ Age _____

DOB _____ , SS# _____ , Sex M [ ] , F [ ]

Mailing Address: _____ , City and Zip _____

Best # to reach you? _____ , others _____

Does the Dr. have permission to leave messages, test results, etc. on your phone? Yes No

Employer _____ , Occupation _____

Marital Status _____ , Pharmacy: _____

Referring Physician: _____ Primary Care Physician : _____

Last Hospitalization: _____ Reason _____ Where: _____

Up to date ? [ ] colonoscopy, [ ] Mammogram, [ ] Any suspicious moles/lesions

Date of last colonoscopy and Dr. _____

Diabetic [ ] Yes [ ] No if yes, [ ] oral [ ] insulin

Current Height: _____ Weight _____

Do You Smoke: _____ if so how much per day _____
Do You Drink alcohol? _____ Never, _____ rarely, _____ , daily. How much? _____

Have you seen either Dr. Brandy, Dr. Zuker or Dr. Galvan in the past? [ ] yes [ ] no
if yes, when and what for: _____

Describe your reason for seeing the Doctor today:

_____

_____

_____

_____

Surgical History: have you ever had surgery or been hospitalized?

Date	Reason	Hospital

Medical History :

Are you taking any medications? Please list name, dose, and reason for taking each medication.

Do you have any allergies to any medications? [ ] yes, [ ] no
if so, please list medication and describe what happens to you when taken:

Have you ever had or do you have any of the following? Check all that apply.

[ ] Arthritis
[ ] Asthma
[ ] Blood clots in legs
[ ] Bronchitis
[ ] Cancer (previous diagnosis of benign tumor)
[ ] Cataracts, Glaucoma, Tunnel Vision
[ ] Colitis
[ ] Diabetes
[ ] Emphysema
[ ] Heart Disease (heart attack, angina, etc)
[ ] Hepatitis, Liver Trouble
[ ] Hernia
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Irregular Heart Beat, Arrhythmia
[ ] Kidney, Urinary Tract Infection
[ ] Menstrual Bleeding, Irregularity, Infections
[ ] Migraine, Frequent Headaches
[ ] Pneumonia
[ ] Psychiatric Illness
[ ] Seizures, Epilepsy
[ ] Stomach Ulcer, Duodenal Ulcer
[ ] Swollen Glands, Lupus
[ ] Thyroid Problems
[ ] Tuberculosis (TB)
[ ] Other Medical Illnesses (Please list below)
[ ] Malignant Hypertension

If You checked any of the above, please explain :

SYSTEM REVIEW: Do you or have you had any of the following? Check all that apply.

General
[ ] Recent weight gain or loss
[ ] Appetite increase, decrease
[ ] Fatigue,weakness, decreased energy
[ ] Fevers, chills, hot flashes, night sweats

Eyes
[ ] Visual difficulty (loss of vision, double,blurred)
[ ] Wear glasses or contact lenses

Ears, Nose, Throat, Mouth
[ ] Loss of hearing
[ ] Earaches
[ ] Chronic sinus problem
[ ] Post nasal drip
[ ] Nose bleeds
[ ] Lumps in neck
[ ] Speech/Voice problems
[ ] Throat dryness/itching
[ ] Throat pain
[ ] Throat clearing

Cardiovascular
[ ] Chest pain (angina)
[ ] Heart palpitations
[ ] Swollen legs or feet
[ ] High blood pressure
[ ] Heart murmurs

Respiratory
[ ] Shortness of breath
[ ] Coughing, wheezing, hoarseness
[ ] Problem snoring/stop breathing
[ ] Coughing up blood

Gastrointestinal
[ ] Bowel Problems – diarrhea,constipation,etc
[ ] Rectal Bleeding, bloody, black or tarry stools
[ ] Abdominal cramping, pain
[ ] Nausea, vomiting
[ ] Heartburn, acid reflux, hiatal hernia
[ ] Difficulty swallowing

Genitourinary
[ ] Trouble urinating,blood in urine,burning
[ ] Frequent urination
[ ] Male testicle pain
[ ] Circumcision
[ ] Female-pain with irregular periods

Skin
[ ] Rashes, burning, bumps
[ ] Color change or growth of moles

Neurological
[ ] Headaches, migraines
[ ] Fainting, dizziness
[ ] Weakness
[ ] Convulsions or seizures
[ ] Stroke or mini stoke

Mental Illness
[ ] Anxiety
[ ] Depression
[ ] Memory loss or confusion

Endocrine
[ ] Always thirsty
[ ] Feel hot or cold
[ ] Other hormone problems

Musculoskeletal
[ ] Muscle, joint aches, pains
[ ] Pains in legs when you walk
[ ] Back pain
[ ] Joint pain of swelling
[ ] Difficulty walking

Hematologic,Lymphatic
[ ] Anemia
[ ] Easy bruising
[ ] Bleeding tendency
[ ] Clotting tendency, Blood clots-legs
[ ] Blood transfusion reaction

If you checked any of the above, please explain:

_____
_____
_____
_____
_____

Yes	No	
[ ]	[ ]	Do you Smoke? How much _____
[ ]	[ ]	Did you ever smoke? How much _____ , how long _____ when did you quit? _____
[ ]	[ ]	Have you ever been exposed to second hand smoke? If yes, please specify number of years exposed. _____
[ ]	[ ]	Do you use street drugs- IV or other? Which drugs? _____
[ ]	[ ]	Do you exercise? How often and what? _____
[ ]	[ ]	Have you or a family member experienced any problems with anesthesia?

Family History : DO NOT IDENTIFY BY NAME

	Age	Disease or illness	**if deceased** age and cause	Comments
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings				
Brother/Sister	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____
Children				
Son/Daughter	_____	_____	_____	_____
Son/Daughter	_____	_____	_____	_____
Son/Daughter	_____	_____	_____	_____
Son/Daughter	_____	_____	_____	_____

Any cancer, diabetes, or heart disease in family [ ] yes [ ] no
explain: _____

I authorize the release of medical information necessary to process claims for medical benefits. I request that payments of authorized Medicare or other insurance benefits be made on behalf to Dr. Brandy, Dr. Zuker, or Dr. Galvan for any services furnished to me.

Signature: _____ Date: _____

FAX TO: 315-393-8965

Patient information:

Name: _____ Phone: (Home) _____-_____
Last First MI (Maiden) (Work) _____-_____
(Cell)_____-_____

Mailing address: _____

Date of birth: _____ Sex: M – F Marital Status: S M D W SEP

Social Security Number: _____

Employer: _____

Guarantor information: Parent information/person responsible for this bill (if different than above)

Name: _____ Phone: _____-_____
Last First MI (Maiden)

Mailing address: _____

Date of birth: _____ Sex: M – F SSN: _____-_____-_____

Employer: _____

Emergency Contact: _____ Phone _____

Primary Insurance: Secondary Insurance:

Insured's name: _____ Insured's name _____

Relationship to patient: _____ Relationship to patient: _____

Date of birth _____ SSN _____ Date of birth _____ SSN _____

Insurance company: _____ Insurance company: _____

ID number _____ ID number _____

Group number: _____ Group number: _____

Employer: _____ Employer: _____.

X _____
(Signature of patient or responsible party) (Date)