



Bradenton  
Surgical Group

# Patient History Questionnaire

Date of Visit: ____/____/____	Last Name:		First:	Middle Initial:	
	Birthday: ____/____/____		Age:		
	Referring Physician:				
	Family Physician:				
What is the reason for your visit?					
Do you take any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I take:			<input type="checkbox"/> Aspirin/Blood Thinners
		1. _____	3. _____	5. _____	
		2. _____	4. _____	6. _____	
Are you allergic to any drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I'm allergic to:			
Do you have any medical problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I have or had at some time:			
		<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Bleeding Problems	
		<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> HIV/AIDS	
		<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Cancer	
Have you ever had surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I had (please include year):			
		1. _____	3. _____	5. _____	
		2. _____	4. _____	6. _____	
Social Habits	<b>Marital Status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			
	<b>Exercise</b>	<input type="checkbox"/> Never <input type="checkbox"/> Several times/week <input type="checkbox"/> Daily			
	<b>Tobacco Use</b>	<input type="checkbox"/> Never <input type="checkbox"/> I smoke ____ pack(s)/day for __ years <input type="checkbox"/> Year Quit _____			
	<b>Alcohol Use</b>	<input type="checkbox"/> Never <input type="checkbox"/> Rare <input type="checkbox"/> Once/week <input type="checkbox"/> Daily			
	<b>Other Drugs</b>	<input type="checkbox"/> Never <input type="checkbox"/> I use/have used:			
Are there any major illness (such as heart disease, diabetes, or cancers) or bleeding disorders in your family?					
<input type="checkbox"/> No	<input type="checkbox"/> Yes, my	Mother has/had: _____			
		Father has/had: _____			
		Siblings have/had: _____			
		Grandparents have/had: _____			
Patient Statement: To the best of my knowledge, the above information is accurate and complete.					
Patient Signature:		Date: ____/____/____		Reviewed by Physician:	



## Patient History Questionnaire: Review of Systems

Last Name:		First:		Middle Initial:	
<p><b>Please check the boxes below next to any illness or problems that you may have or had at one time.</b></p>					
<b>General</b>			<b>Musculoskeletal</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Weight loss (more than 10lbs/month) <input type="checkbox"/> Fevers <input type="checkbox"/> Generalized Weakness <input type="checkbox"/> Recent travel abroad or sick contacts <input type="checkbox"/> Car accidents		<input type="checkbox"/> None	<input type="checkbox"/> Arthritis <input type="checkbox"/> Joint pain or swelling <input type="checkbox"/> Back pain or spine disease How far can you walk without having pain or being tired? _____ blocks	
<b>Neurologic</b>			<b>Endocrine</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Strokes, Mini-Stroke or TIA <input type="checkbox"/> Brain Tumor or Aneurysm <input type="checkbox"/> Slurred speech <input type="checkbox"/> Paralysis or Seizures		<input type="checkbox"/> None	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Cushing's or Adrenal Disease	
<b>Head/Neck</b>			<b>Genitourinary</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Masses or swelling in throat or neck <input type="checkbox"/> Exposure to neck radiation <input type="checkbox"/> Trouble with vision		<input type="checkbox"/> None	<input type="checkbox"/> Trouble urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney failure/dialysis	
<b>Heart</b>			<b>Gastrointestinal</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Chest pain or angina <input type="checkbox"/> Heart Failure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Pacemaker <input type="checkbox"/> Murmur <input type="checkbox"/> Heart Catheterization (Year _____) <input type="checkbox"/> Heart surgery (Year _____) <input type="checkbox"/> Last stress test was: ___/___/___		<input type="checkbox"/> None	<input type="checkbox"/> Jaundice (skin/eyes turn yellow) <input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Constipation or Diarrhea <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Last colonoscopy was ___/___/___	
<b>Lungs</b>			<b>Vascular</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Cough or Shortness of breath <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Asthma, Emphysema, COPD		<input type="checkbox"/> None	<input type="checkbox"/> Leg pain when walking or at rest <input type="checkbox"/> Aneurysms <input type="checkbox"/> Leg/foot ulcers or wounds <input type="checkbox"/> Blood clots	
<b>Women</b>			<b>Men</b>		
<ul style="list-style-type: none"> <li>• Age of first menses: _____</li> <li>• Number of pregnancies: ____/ Abortions: _____</li> <li>• Age of first pregnancy: _____</li> <li>• Last menstrual period: ___/___/_____</li> <li>• Last mammogram was: ___/___/_____</li> </ul>			<input type="checkbox"/> None	<input type="checkbox"/> Prostate problems <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Testicular pain or swelling <input type="checkbox"/> Hernias or Previous Hernia Surgery <input type="checkbox"/> Sexually transmitted diseases	
<input type="checkbox"/> None	<input type="checkbox"/> Female/Pelvic Surgery <input type="checkbox"/> Breast mass or cancer <input type="checkbox"/> Sexually transmitted diseases				
<p><b>Patient Statement: To the best of my knowledge, the above information is accurate and complete.</b></p>					
Patient Signature:			Date: / /		Reviewed by Physician:



## Patient Registration Form

Last Name:		First Name:		Middle Initial:	
Birthday: __ / __ / __ __ __		Social Security #:		<input type="checkbox"/> Female <input type="checkbox"/> Male	
Referring Physician:					
<b>Local Address</b>					
	Street		City		State Zip
	Home Phone #		Cell Phone #		E-mail Address
<b>Permanent Address</b> (If Different from Above)					
	Street		City		State Zip
	Home Phone #		Cell Phone #		E-mail Address
<b>Emergency Contact Person:</b>			Phone #:	Relationship:	
<b>Primary Insurance</b>	Please check if being treated for an <input type="checkbox"/> <b>Auto Accident</b> or <input type="checkbox"/> <b>Worker's Compensation</b>				
	Insurance Company		Name of Insured Subscriber		
	Subscriber's Birth Date		Subscriber's Social Security		Employer
<b>Secondary Insurance</b>	Insurance Company		Name of Insured Subscriber		
	Subscriber's Birth Date		Subscriber's Social Security		Employer
<b>Financial Policy:</b>					
We are committed to providing you with the best care and we will be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.					
<ul style="list-style-type: none"> <li>● All patients must complete our "Patient Registration" form and present insurance cards BEFORE seeing the physician.</li> <li>● We will be happy to file insurance claims as a courtesy to you as our patient.</li> <li>● Payment for services NOT COVERED by insurance is to be paid at the time of service.</li> <li>● We accept Cash, Checks, and VISA &amp; MASTERCARD. We can also make payment arrangements if necessary.</li> <li>● Any account over 90 days without payment is subject to being forwarded to a collection agency and therefore subject to collection fees, attorney fees, and court costs.</li> </ul>					
<b>Patient Statement:</b> I understand that I am ultimately responsible for any services NOT COVERED by my insurance company. I authorize my insurance company to pay Bradenton Surgical Group, P.A. (Dr. Gary M. Bunch) directly for services rendered by him or his office.					
Patient /Legal Guardian Signature:				Date: / /	