Laird + Laird
Surgical Associates, PLLC

The following forms are comprehensive, and take about 15 minutes to complete.
All of the information is needed in order to:

- provide medical care to you
- assess risks & benefits of treatment
- contact you
- file insurance claims
- meet government regulations
- explain office policies and fees

Unfortunately, data does not transfer from the hospital or your PCP's office.
Please complete all sections, and feel free to ask us for help if any portion is unclear.

Today's Date: _____ / _____ / _____

Name: ____________________ ____
Last First Middle Suffix

Birthdate: _____ / _____ / _____ Age: __________ Gender: M F

Street Address: ____

City: ______________________________ State: _____ Zip code: ______________

Home or Main Phone: ______________________ Cell Phone: _______________________

Work Phone (only list if it's ok to call you at work): ______________________________

E-mail address: ____

Race: White Black Asian Native American Other: ______________________

Ethnicity: Hispanic Non-hispanic

Social Security Number (last 4 only): ____________ Marital Status: S M W D

Preferred Language: English Other: ______________________________________

Primary Care Physician: ____

Referring Physician: ____

Other Physician(s) who you see frequently: ____

Is Today's Visit is related to an Auto Accident or Work Injury?

☐ Auto accident ☐ Work injury Date of accident or injury: _____ / _____ / _____

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Patient Name: ______________________________

Insurance Information

Primary Health Insurance: ____

Subscriber Full Name: _____________________ ____
Last First Middle Suffix

Relationship to you: ____________________ Subscriber's Birthdate: _____ / _____ / _____

Secondary Health Insurance: ____

Subscriber Full Name: _____________________ ____
Last First Middle Suffix

Relationship to you: ____________________ Subscriber's Birthdate: _____ / _____ / _____

Current Employment

Employer: __________________________________ Occupation: ________________________

Emergency Contact

Name: _______________________________________ Phone: _______________________

Relationship: __________________________

Pharmacy

Pharmacy Name: ____

Location: ____

Appointment Reminders

Laird and Laird Surgical Associates uses automated appointment reminders. Please select your preferred method to receive these reminders.

☐ Text message on cell phone ☐ E-mail ☐ Voice message on home or main phone

☐ I do not want to receive automated appointment reminders. I understand no show fees will apply if I miss my appointment or cancel with less than 24 hours notice.

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Patient Name: ______________________________

Reason for today's visit:

Allergies:

Are you allergic to latex? ☐ Yes, reaction: _________________________ ☐ No

Do you have any food or drug allergies? ☐ No

Food or Medication	Reaction

Have you ever had a bad reaction to anesthesia?

☐ Yes, reaction: ____ ☐ No

Medical History:

☐GERD
☐Heart arrhythmia
☐Asthma
☐Stomach ulcers
☐Heart attack
☐COPD
☐Diverticulitis
☐Stroke
☐Arthritis
☐Colon polyps
☐Blood clots (PE or DVT)
☐Anxiety
☐Crohn's or UC
☐Anemia
☐Depression
☐High blood pressure
☐Diabetes
☐Endometriosis
☐High cholesterol
☐Hypothyroidism
☐Cancer, Type: ___________

Other:

____

____

Surgical History: Please list all surgeries you have had in your lifetime

☐Tonsils
☐Umbilical or Ventral Hernia
☐Cataract
☐Appendix
☐Knee
☐Back surgery
☐Gallbladder
☐Hip
☐Neck surgery
☐Colon
☐Cardiac cath
Other:
☐Bariatric
☐EGD
____
☐Inguinal Hernia
☐Colonoscopy
____

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Patient Name: ______________________________

Family History: Does anyone in your family have any of the following?

☐High Cholesterol who? ______________ ☐COPD or Asthma who? ______________

☐High Blood Pressure who? ______________ ☐Liver disease who? ______________

☐Heart Attack who? ______________ ☐Kidney Disease who? ______________

☐Diabetes who? ______________ ☐Urinary disease who? ______________

Other disease: ____

☐Lung cancer who? ______________ age at diagnosis? _______________

☐Breast Cancer who? ______________ age at diagnosis? _______________

☐Ovarian Cancer who? ______________ age at diagnosis? _______________

☐Colon Cancer who? ______________ age at diagnosis? _______________

☐Crohn's or Ulcerative Colitis who? ______________ age at diagnosis? _______________

☐Prostate Cancer who? ______________ age at diagnosis? _______________

☐ Other Cancer what kind? __________ who? __________ age at diagnosis? ________

Social History and Habits:

Do you have any religious or personal beliefs that prevent you from receiving a blood transfusion?

☐ Yes, please explain: ______________________________________ ☐ No

Place of birth: ___________________________________

How much alcohol do you consume? ____

Do you use tobacco? ☐ Yes, ______ packs per day for ______ years ☐ Never smoker

☐ Quit _____ years ago, on average smoked ______ packs per day for ______ years

☐ Chew tobacco for ______ years

Do you use any recreational drugs, including medical marijuana?

☐ Yes, please list: ____ ☐ No

Medications:

Do you take any blood thinners, such as Aspirin, Plavix, or Coumadin? ☐ Yes ☐ No

Do you bruise or bleed easily? ☐ Yes ☐ No

Please list all current prescriptions, over the counter medications, and vitamins. Attach an extra sheet if needed.

Medication	Dose	Frequency	Reason

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Patient Name: ______________________________

Review of Systems Circle any problems you currently have

Constitutional	Poor appetite, weakness, weight loss, fever, chills, excessive sweating, light-headed
HEENT	Glasses, cataracts, glaucoma, sensitivity to light, vision changes, eye surgery Hearing loss, vertigo, tinnitus, frequent nose bleeds, hoarseness, change in sense of smell Upper dentures, lower dentures, gum problems, mouth pain, loss of taste
Pulmonary	Shortness of breath, cough, coughing up blood, wheezing
Cardiovascular	Difficulty breathing at night or when lying down, chest pain/pressure, palpitations, syncope, leg swelling, murmur, claudication, aneurysm, Raynaud's
Gastrointestinal	Difficult or painful swallowing, abdominal pain, heartburn, nausea, vomiting, vomiting blood, diarrhea, constipation, black stool, blood in stool, colitis, hemorrhoids, gallstones, jaundice, hepatitis, pancreatitis, hernia
Genitourinary	Painful urination, urgency, frequency, frequent nighttime urination, incontinence, blood in urine, kidney stones, kidney failure, frequent UTI
Male	Impotence, benign prostate disease, prostate cancer, STD, sexual dysfunction
Female	Abnormal bleeding, irregular periods, painful intercourse, infertility, PMS, STD
Musculoskeletal	Pain, stiffness, swelling, deformity, arthritis, Myasthenia gravis
Neurological	Numbness in a body part, partial or complete paralysis, headaches, head trauma, syncope, stroke, TIA, tremors, seizures, difficulty speaking, gait changes
Skin	Excessive itching, rash, mole changes, keloids, skin cancer, tattoos, hair changes
Hematologic	Sickle cell, leukemia, blood transfusions, easy bruising, bleeding disorder
Endocrine	Heat intolerance, cold intolerance, radiation exposure
Psychiatric	Psychosis, memory loss, psychiatric treatment
Infectious	HIV/AIDS, Hepatitis B or C, rheumatic fever, TB

Patient Acknowledgement:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes to my medical status.

____ ____________________

Signature of Patient, Parent, or Guardian Date

Physician Review:

I have reviewed the information provided by the patient. Any necessary additions, alterations, or deletions have been made by myself or my staff.

____ ____________________

Signature of Physician Date