Family/Primary Care Doctor: _____ Referring Doctor _____Pharmacy_____

Patient _____
(last) (first) (middle initial)

Date of Birth _____ **Sex :** Male Female

Mailing Address _____ City _____ Zip _____

Home Phone _____ok to leave message ___ Work Phone _____ ok to leave message___

Cell Phone _____ ok to leave message___

Email address _____

Marital Status: _____

Race: White African American Asian Other:_____

Ethnicity: Not Hispanic Hispanic or Latino Other:_____

Reason for today's visit:
_____
_____
_____

Complete this box if patient is insured under a parent:

Father's Name _____ Mother's Name _____

Father's Work /cell phone _____ Mother's work/cell phone _____

Father's birthdate _____ Mother's birthdate _____

Address_____ Address_____

_____ _____

Relative or friend locally for use in an emergency *please provide an alternative number to your own.

Name_____ Relationship _____

Home phone _____ cell phone _____ work Phone _____

Signature _____ **Date** _____

NAME:_____**DOB:**_____

CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS	**Dosage if known**	**Directions**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Do we have your permission to retrieve you medication history from the national prescription data base: Yes ____No____

FAMILY HISTORY – circle all that apply

None Family History unknown. Adopted.

Anesthesia reactions:	Mother	Father	Brother	Sister	Grandparent
Bleeding tendencies:	Mother	Father	Brother	Sister	Grandparent
Skin Cancer:	Mother	Father	Brother	Sister	Grandparent
Breast Cancer:	Mother	Father	Brother	Sister	Grandparent
Other Cancer:	Mother	Father	Brother	Sister	Grandparent
Heart disease:	Mother	Father	Brother	Sister	Grandparent
Thyroid disease:	Mother	Father	Brother	Sister	Grandparent

SOCIAL HISTORY – circle all that apply

TOBACCO

CIGARETTE SMOKING
Never Smoked
Current Smoker
Former Smoker **Quit in year** _____

SMOKE A PIPE
CHEW TOBACCO
SMOKE CIGARS

How often do you smoke cigarettes? EVERYDAY SOME DAYS
How many cigarettes do you smoke a day? _____
How soon after you wake up do you smoke your first cigarette? _____

ALCOHOL

In the last year have you consumed an alcoholic beverage? Yes No

If so how often do you drink? Monthly or less 2 to 4 times a month 2 to 3 times a week more

On average how many drinks do you have a day? _____

How often did you have 6 or more drinks on one occasion in the past year? _____

COFFEE/CAFFEINE _____ cup(s) per day

DRUG USE Current – None
marijuana
Other: _____

Former - None
marijuana
Other:_____

Name:_____DOB:_____

PAST SURGICAL HISTORY AND APPROXIMATE YEAR OF SURGERY

Appendectomy _____
Gall bladder removal _____
CABG _____
Coronary artery stenting _____
Coronary angioplasty _____
Pacemaker placement _____
Hysterectomy _____
Hernia repair _____
Prostatectomy _____
Knee replacement (Left Right Bilateral) _____
Hip replacement (Left Right Bilateral)_____
Breast lumpectomy w/ radiation(Left Right) _____
Breast lumpectomy without radiation(Left Right) _____
Bilateral Mastectomy with radiation (Left Right)_____
Breast reduction _____
Tonsillectomy _____
Thyroidectomy _____
Left or Right thyroid lobectomy _____
Septoplasty _____
Rhinoplasty _____
Sinus surgery _____

COSMETIC

Breast augmentation - silicone saline _____
Breast lift _____
Facelift _____
Neck lift _____
Upper Blepharoplasty _____
Lower Blepharoplasty _____
Otoplasty _____
Laser resurfacing of face _____
Abdominoplasty _____
Liposuction _____
LASIK _____
RK _____

OTHER: _____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY – circle all that apply

HEART
Hypertension (High blood pressure)
Hypercholesterolemia (High Cholesterol)
Coronary Artery Disease
Heart attack - year(s):_____
Coronary artery stenting
Atrial fibrillation
Other heart arrhythmia (irregular heartbeat)
Pacemaker
Congestive Heart Failure

LUNGS
COPD (chronic lung disease)
Bronchitis
Emphysema
Asthma
Obstructive Sleep apnea
TB

CIRCULATION
Anemia
Bleeding disorder
Blood clots
DVT (blood clot in leg)
Pulmonary embolism

GASTROINTESTINAL
GERD/reflux
Peptic Ulcer
Cirrhosis Hepatitis A B C

EYE
Glaucoma
Cataracts
Lasik
RK

ENDOCRINE
Diabetes Type I
Diabetes Type II
Hypothyroidism (low)
Hyperthyroidism (high)

KIDNEY
Chronic kidney disease
Kidney failure
Kidney stones

CANCER
Skin - Melanoma
BCC
SCC
Type unknown

Cancer
Type: _____
Year completed treatment:
Surgery: Yes No
Radiation: Yes No
Chemotherapy: Yes No

Type: _____
Year completed treatment:
Surgery: Yes No
Radiation: Yes No
Chemotherapy: Yes No

ENVIRONMENTAL ALLERGIES
Previous Allergy Testing -
Yes No
Sensitive to: Trees
Grasses
Weeds
Mold
Pollens
Dogs
cats
Previous Allergy Shots –
Yes No

CHEMICAL DEPENDENCY
Alcohol
Drugs – type:
Rheumatic fever

INFECTIOUS DISEASE
HIV disease
Rheumatic fever

NEUROLOGIC
Seizure disorder
Stroke/TIA – year(s):

PSYCHIATRIC
Depression
Bipolar disorder
Anxiety
Other:_____

OTHER MEDICAL CONDITION(S) NOT LISTED

1._____

2. _____

3._____

Name:_____ DOB:_____

Review of Systems Complete - Circle all that apply *TO you currently*

Constitutional:
unexplained weight loss
fever
chills
night sweats

Eyes:
vision changes
double vision
eye irritation
dry eyes
excessive tearing
contact lenses
sensitivity to light

Ear Nose Throat:
hearing loss
ringing in the ears
dizziness
ear pain
ear drainage
post nasal drip
difficulty breathing through nose
sinus infections
dental problems
tooth pain
dentures
voice changes

Cardiovascular:
chest pain
heart murmur
irregular heart beat

Respiratory:
shortness of breath
use of oxygen
recent cough

NONE

Gastrointestinal:
heartburn
vomiting
difficulty swallowing solids
difficulty Swallowing liquids

Musculoskeletal:
bone or joint injuries
leg swelling
joint pain
arthritis

Integumentary/Skin:
new or changing lesions
cold sores
herpes

Neurologic:
sensory loss/numbness
weakness
headache
fainting spells
head injury

Psychiatric:
depression
anxiety
bipolar

Hematologic/Lymphatic:
bleeding disorders
anemia
easy bruising

Allergic/Immunologic:
seasonal allergies
hay fever

Other :

_____
_____
_____
_____
_____

Purpose: This form is used to confirm that individual has received our Notice of Privacy (Blue/Green Page)

I , _____, acknowledge that I have received Bruce V. Lattyak, M.D., Inc. Physician Practice's Notice of Privacy Practices. I have had a full opportunity to read and consider the contents of this Notice of Privacy Practices.

X Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:
Personal Representative's name: _____Relationship _____

FINANCIAL POLICY (ORANGE Page)

Appointments which are not kept or which are canceled without 24 hours notice may be charged a $75.00 fee which cannot be billed to your insurance. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and may be discharged from the practice.
I understand that medical insurance plans vary and there may be limitations and exclusions in my plan of which I or Dr. Lattyak may not be aware. I also understand that actual benefits can be determine only by my insurance company and only after a claim is filed. This applies to all medical coverage including Medicare and Medical.
I agree to be responsible for the charges not covered by my insurance plan.

X Signature: _____Date:_____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:
Personal Representative's name: _____Relationship _____

PHOTOGRAPHY CONSENT

I consent to the photographing of the treatment / procedure, for documentation of my care; for my medical file or in the event my insurance company requests such photos.

X Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:
Personal Representative's name: _____Relationship _____

NOTICE TO CONSUMERS

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