Peoria Surgical Group

Welcome to Our Practice

As a new patient or a renewing patient, please fill out the information found below to the best of your ability.

Patient Name (first, middle, last) | **Social Security No.** | Date

Address | **City/State/Zip** | **Primary Phone # (w/ area code)**

Male/Female | **Age** | **Date of Birth** | **1st Alternate # (w/ area code)**

Marital Status ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed | **2nd Alternate # (w/ area code)**

Employer Status ___ Employed ___ Self-Employed ___ Retired ___ Unemployed ___ Disabled

Employer & Occupation

Primary Care Physician

Referring Provider (if different than Primary Care)

Name of preferred Pharmacy | Address/City/State/Zip | Telephone

Which Hospital do you or your insurance prefer for your surgical needs? (Circle the appropriate one)

OSF Unity Point Methodist Unity Point Proctor

Which hospital or lab do you or your insurance prefer for testing to be sent to? (Circle the appropriate one)

OSF Unity Point Methodist Unity Point Proctor LabCorp Quest

(Please complete this section AND give your insurance card(s) to receptionist to make a copy)

Primary Insurance Information

Insurance Company Name

Policy Holders SS# | **GROUP #** | **MEMBER ID#/MEDICARE #**

Policy Holders Name (first, middle, last) | **Relationship to Patient & DOB**

Policy Holder's Address (if different than patient) | City / State / Zip

Secondary Insurance Information

Insurance Company Name

Policy Holders SS# | **GROUP #** | **MEMBER ID#/MEDICARE #**

Policy Holders Name (first, middle, last) | **Relationship to Patient & DOB**

Policy Holder's Address (if different than patient) | City / State / Zip

Workman's Comp Information

Were you hurt on the job? YES NO | **Date of injury:** / /

Name of Employer / Company where you were when you were hurt

Contact Person | **Contact #**

Claim # | **Name of W/C Insurance Company**

Address | **City / State /Zip**

Last Date Worked / / | **Date returned to work** / /

Patient Social History:

Caffeine Intake: ___ Coffee ___ Tea ___ Soda ___ Energy drinks Bottles, Cans or Cups/day _____

Use of Alcohol: ___Never ___Rarely ___Moderate ___Daily Drinks/wk (Whiskey, Beer +/or Wine) _____

Use of Tobacco: ___Never ___Rarely Previously, but quit, when?: _____ Currently packs/day_____ Years _____

Use of Drugs: ___Never ___Rarely Previously, but quit, when?: _____

Excessive exposure at home or at work: ____Fumes ____Dust ____Solvents ____Airborne particles ____Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Please list your current medications, vitamins & herbal supplements (or give receptionist a printed list to copy)

Medication	Reason you take	Dosage & Times per day	Prescribing Doctor

Allergies: (Please list allergies & reactions. If None, please mark box.)

☐ **NONE**

Past Surgeries: (Please list all past surgeries. If None, please mark box.)

☐ **NONE**

Patient Name: _____ **DOB:** _____

Today's date: _____

You currently reside? ☐ Independently ☐ Assisted Living Facility ☐ Nursing Home

Review of Systems

Please indicate any symptoms you are currently experiencing

Const

Recent weight loss/gain # of pounds _____

☐ Fever ☐ Chills ☐ Poor appetite

☐ Fatigue ☐ Insominia ☐ Night sweats

Eyes

☐ Wear glasses/contact lenses ☐ Eye pain

☐ Decrease in vision ☐ Double vision ☐ Blurry vision

☐ Eye discharge ☐ Eye redness ☐ Dry eyes

ENMT

☐ Ear pain ☐ Hearing loss ☐ Ear discharge

☐ Nose bleeds ☐ Sinus problems ☐ Sore throat

CV

☐ Chest pain ☐ Palpitation ☐ Irregular pulse

☐ High blood pressure ☐ Pain while at rest

☐ Low blood pressure

☐ Swelling of feet, ankles or hands

How far can you walk without pain? _____

Resp

☐ Chronic or frequent coughs ☐ Wheezing

☐ Shortness of breath while walking ☐ Spitting up blood

☐ Shortness of breath while lying flat

GI

☐ Abdominal pain ☐ Heartburn ☐ Vomiting

☐ Diarrhea ☐ Constipation ☐ Vomiting blood

☐ Hemorrhoids ☐ Stomach ulcer ☐ Jaundice

☐ Rectal bleeding or blood in stool ☐ Trouble swallowing

☐ Change in bowel movement or painful bowel movements

Genitourinary

☐ Frequent urination ☐ Urinary Retention ☐ Blood in urine

☐ Burning or painful urination

☐ Incontinence or dribbling ☐ Male - testicle pain

☐ Change in force of stream when urinating

Skin / Breast

☐ Nail changes ☐ Mole changes ☐ Hair loss

☐ Rash or itching ☐ Breast pain ☐ Breast lump

Musculo

☐ Joint pain ☐ Muscle weakness ☐ Arthritis

☐ Frequent leg cramps ☐ Cold extremities ☐ Back pain

☐ Muscle pains or cramps (aches) ☐ Joint swelling

Psych

☐ Memory loss/confusion ☐ Panic Attacks

☐ Depressed mood ☐ Nervousness/Anxiety

Neuro

☐ Headaches ☐ Light headed or dizzy

☐ Loss of balance ☐ Numbness ☐ Tingling sensation

☐ Paralysis ☐ Head injury ☐ Slurred speech

☐ Convulsions or seizures

Endocrine

☐ Prescription steroid use ☐ Heat intolerance

☐ Change in skin pigment ☐ Cold intolerance

☐ Excessive thirst ☐ Excessive urination

Hematologic /Lymphatic

☐ Bleeding or bruising tendency ☐ Anemia

☐ Phlebitis or blood clots in legs ☐ Enlarged glands

☐ Chemo treatments currently ☐ Radiation treatments currently

Allergic /Immun

☐ Frequent infections

☐ Positive tuberculin skin test (TB)

Past Medical History

Please indicate any personal history below, past or present

Date of last Colonoscopy? _____

Date of last PSA? _____

Date of last Mammogram? _____

☐ Glaucoma ☐ Cataracts

☐ Blind ☐ Eye surgery

☐ Deaf ☐ Laryngeal Cancer

☐ Heart murmur ☐ Rheumatic fever ☐ Heart disease

☐ Mitral valve prolapse ☐ Varicose veins ☐ Pacemaker/AICD

☐ Poor circulation ☐ Heart surgery ☐ Hypotension

☐ Congenstive Heart Failure (CHF) ☐ Hypertension

☐ Peripheral Vascular Disease (PVD) ☐ Atrial Fibrillation

☐ Coronary angiogram ☐ History of heart attack

☐ Hypercholesterolemia

☐ Sleep apnea ☐ Asthma ☐ Lung Cancer

☐ Bronchitis ☐ Pneumonia

☐ Emphysema or COPD

☐ Cirrhosis/Liver disease ☐ GERD

☐ Hepatitis ☐ History of Diverticulitis

☐ Crohn's disease ☐ Lynch Syndrome / HNPCC

☐ Ulcerated Colitis ☐ Esophageal Cancer

☐ History of colon / rectal cancer ☐ Constipation

☐ Frequent UTI's ☐ Kidney stones ☐ Kidney disease

☐ Kidney Failure - Hemo Dialysis or CAPD ☐ Ovarian Cancer

☐ Tubal ligation ☐ Hysterectomy ☐ Uterine Cancer

☐ Skin sores ☐ Psoriasis ☐ Eczema

☐ Skin Cancer ☐ Nipple discharge ☐ Breast Pain

☐ Breast mass ☐ History of Breast Cancer

☐ Rheumatoid arthritis ☐ Hernia

☐ Fibromyalgia ☐ Degenerative Disc Disease

☐ Osteoarthritis

☐ Insomnia ☐ Bipolar disease ☐ Anxiety

☐ Depression ☐ Schizophrenia

☐ Vertigo ☐ Brain tumor ☐ Migraines

☐ Tremors ☐ Stroke ☐ TIA

☐ Thyroid disease ☐ Goiter

☐ Diabetes - oral medication

☐ Diabetes - insulin

☐ Cancer ---- Type? _____

☐ Past transfusion-blood/plasma

☐ Hepatitis ☐ HIV +

Authorization

To the best of my knowledge, the questions in this packet (pages 1-3) have been accurately answered. I understand that providing incorrct information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need if necessary for my care.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ Date: _____