



**Marshall Surgical Associates  
Marshall, MO 65340**

DATE: \_\_\_\_\_  
PATIENTS NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_  
PHONE: \_\_\_\_\_ S.S.N.: \_\_\_\_\_  
MAIDEN NAME: \_\_\_\_\_

Single Married Widowed Separated Divorced Male Female Race: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

**PATIENT EMPLOYER:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Employment Status: Full-time Part-time Retired Unemployed

**PERSON TO NOTIFY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**NEXT OF KIN** (If same as person to notify, leave blank.):

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**GUARANTOR** (Who is responsible for bill: self, spouse, etc.):

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ S.S.N.: \_\_\_\_\_

**GUARANTOR EMPLOYER**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Employer Phone: \_\_\_\_\_  
Employment Status: Full-time Part-time Retired Unemployed

Reason for Visit: \_\_\_\_\_  
Type of Accident related to this visit: \_\_\_\_\_

**READ AND SIGN**

I hereby authorize payment directly to Marshall Surgical Associates, of any insurance coverage for surgery or hospital charges, and authorize them to release any information necessary to process these insurance claims.

I understand that I am fully responsible for all social services and charges, including any balance due after payment of insurance and that insurance coverage does not necessarily pay all charges.

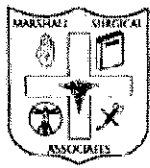
I also understand that any co-pays and deductibles are due and payable when services are rendered.

I, the undersigned, authorize treatment by the doctor in this office.

Signature: \_\_\_\_\_  
(IF MINOR, PARENT OR GUARDIAN SIGNATURE)

Date: \_\_\_\_\_

**(A photocopy of the above authorization will be accepted as valid.)**



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**PATIENT HEALTH HISTORY**

**PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

**Past Health History:** Please list all previous hospitalization, surgeries, serious injuries, and blood transfusions. Include year and age.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Your Medical History:** Please circle **Yes** or **No** if you have any of the following medical problems.

High blood pressure	Yes	No	Diabetes	Yes	No	Heart trouble	Yes	No
Respiratory problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding problems	Yes	No	HIV/AIDS	Yes	No	Other Problems	_____	
Anesthesia Problems	Yes	No						

**Allergies:** \_\_\_\_\_

**Current Medications:** Please list all medications which you are currently taking. (Be sure to include over the counter medications.)

Name of Medication	Dose	How Often	Date Began	Date Last Taken

**Social History:**

Language(s) spoken: \_\_\_\_\_

Reading, Writing, Speech, Hearing Deficit: Yes No If yes, please explain: \_\_\_\_\_

Tobacco Use: Never Quit/when: \_\_\_\_\_ Current smoker/packs per day: \_\_\_\_\_

Alcohol Use: Never Rarely Weekly Daily How much/type? \_\_\_\_\_

Drug Use: Never Rarely Weekly Daily How much/type? \_\_\_\_\_

How much coffee, tea, and/or soda do you drink in a day? \_\_\_\_\_

What activities do you do for fun? \_\_\_\_\_

Highest grade completed? \_\_\_\_\_

Occupation: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_



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**PATIENT HEALTH HISTORY**

**REVIEW OF SYSTEMS (ROS):** Please circle **Yes** or **No** if you have any of the following problems.

**Constitutional**

Good general health    Yes    No  
 Recent weight change    Yes    No  
 Night sweats/fevers    Yes    No  
 Fatigue    Yes    No

**Ears/Nose/Mouth/Throat**

Hearing loss or ringing    Yes    No  
 Sinus problems    Yes    No  
 Nose Bleeds    Yes    No  
 Sore throat/voice change    Yes    No

**Eyes**

Wear glasses/contacts    Yes    No  
 Blurred/double vision    Yes    No  
 Eye disease or injury    Yes    No  
 Glaucoma    Yes    No

**Cardiovascular**

Chest Pain    Yes    No  
 Palpitation    Yes    No  
 Heart trouble    Yes    No  
 Swelling hands/feet    Yes    No

**Respiratory**

Shortness of breath    Yes    No  
 Cough    Yes    No  
 Wheezing/Asthma    Yes    No  
 Coughing up blood    Yes    No

**Gastrointestinal**

Nausea/vomiting    Yes    No  
 Abdominal pain    Yes    No  
 Rectal bleeding    Yes    No  
 Bowel problems    Yes    No  
 Reflux    Yes    No

**Musculoskeletal**

Muscle pain or cramps    Yes    No  
 Stiffness/swelling joints    Yes    No  
 Joint pain    Yes    No  
 Trouble walking    Yes    No

**Neurological**

Frequent headaches    Yes    No  
 Paralysis or tremors    Yes    No  
 Convulsions/seizures    Yes    No  
 Numbness/tingling    Yes    No

**Integumentary (Skin/Breast)**

Change in hair/nails    Yes    No  
 Rashes/itching    Yes    No  
 Breast lump    Yes    No  
 Breast pain/discharge    Yes    No

**Endocrine**

Excessive thirst    Yes    No  
 Excessive urination    Yes    No  
 Thyroid disease    Yes    No  
 Hormone problem    Yes    No

**Hematologic/Lymphatic**

Bruise easily    Yes    No  
 Slow to heal    Yes    No  
 Enlarged glands    Yes    No

**Genitourinary – Male Only**

Blood in urine    Yes    No  
 Kidney stones    Yes    No  
 Sexual problems    Yes    No  
 Testicle pain    Yes    No

**Genitourinary – Female Only**

Blood in urine    Yes    No  
 Kidney stones    Yes    No  
 Sexual problems    Yes    No  
 Menstrual problems    Yes    No

**Psychiatric**

Insomnia    Yes    No  
 Confusion/memory loss    Yes    No  
 Depression    Yes    No

**Family Health History:** To your knowledge, do any of your immediate family members have the following? If yes WHO?

Heart Disease \_\_\_\_\_ Stroke \_\_\_\_\_  
 Diabetes \_\_\_\_\_ Lung Disease \_\_\_\_\_  
 Cancer/Type \_\_\_\_\_ Anesthesia Problems \_\_\_\_\_

**PATIENT STATEMENT:** To the best of my knowledge, the above information is accurate and complete.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTES:**

**PHYSICIAN STATEMENT:** I have reviewed the questionnaire.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_