ALSA
Advanced Laparoscopic Surgery Associates Medical Group, Inc.

Medical History Questionnaire

Please complete the following questionnaire and bring it with you to your appointment. It is important that you complete this form as accurately as possible so that we can provide you with the highest level of quality medical care.

PATIENT INFORMATION

Patient Name:		☐ Male ☐ Female	
Race/ Ethnicity: ☐Caucasian ☐Black ☐Hispanic ☐Asian ☐Native American ☐Native Hawaiian ☐Asian Pacific American ☐Subcontinent Asian American ☐Pacific Islander ☐American Indian or Alaskan Native ☐Black Non-Hispanic ☐White Non-Hispanic ☐More Than One Race ☐Decline To State ☐Don't Know ☐Other			
Language:			
Birthdate:	Soc Sec No:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	
Mailing address:		Apt:	
City:		State:	Zip:
Home phone No:	Work phone No:	Mobile No:	
E-mail			

EMPLOYER INFORMATION

Patient employment status:	Retirement date:	
Employer/School name:		
Patient occupation:	Phone No:	
Employer address:		
City:	State:	Zip:

RESPONSIBLE PARTY

Name of person responsible:		Relationship to patient:	
Birthdate:	Phone No:	Soc Sec No:	
Mailing address:		Apt:	
City:		State:	Zip:
Employer/School name:		Phone No:	
Employer address:			
City:		State:	Zip:

EMERGENCY CONTACT(S)

Name:	Relationship to patient:
Home phone No:	Work phone No:
Name:	Relationship to patient:
Home phone No:	Work phone No:

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REFERRING PHYSICIAN

Name:	Specialty:	
Mailing address:	Suite:	
City:	State:	Zip:
Work phone No:		

PRIMARY INSURANCE INFORMATION

Carrier/Plan:		Phone No:	
Policy No:	Group No:	Claim No:	
Name of insured:	Patient's relationship to insured:		
Insured's mailing address:		Apt:	
City:		State:	Zip:
Insured's birthdate:	Insured's Soc Sec No:		

SECONDARY INSURANCE INFORMATION

Carrier/Plan:		Phone No:	
Policy No:	Group No:	Claim No:	
Name of insured:	Patient's relationship to insured:		
Insured's mailing address:		Apt:	
City:		State:	Zip:
Insured's birthdate:	Insured's Soc Sec No:		

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S).
I AUTHORIZE AND DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO ADVANCED LAPAROSCOPIC SURGERY ASSOCIATES (ALSA) AND/OR TO THE PHYSICIAN(S) AND/OR OTHER CARE PROVIDERS WHO RENDERED SERVICES AT THE OFFICE.
I UNDERSTAND THAT MY INSURANCE CARRIER MAY REQUIRE AN AUTHORIZATION NUMBER, PRECERTIFICATION AND/OR REFERRAL. WITHOUT THIS DOCUMENTATION, I UNDERSTAND THAT MY INSURANCE CARRIER MAY DENY BENEFITS. IF MY INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED BY ADVANCED LAPAROSCOPIC SURGERY ASSOCIATES AND/OR TO THE PHYSICIAN(S) AND/OR OTHER CARE PROVIDERS WHO RENDERED SERVICE(S), I AGREE TO BE RESPONSIBLE FOR PAYMENT.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE SUCH AS, BUT NOT LIMITED TO, DEDUCTIBLE AND CO-INSURANCE AMOUNT(S).
I FURTHER UNDERSTAND THAT ALSA CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF MY CLAIM(S) OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM.
I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITHIN THE LIMITS OF YOUR CREDIT POLICY.

Signature:	Date:

Signature of the person responsible for payment

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PHYSICIANS

Primary Care:	Phone No:	
Mailing address:	Suite:	
City:	State:	Zip:

Cardiology:	Phone No:	
Mailing address:	Suite:	
City:	State:	Zip:

OBGYN:	Phone No:	
Mailing address:	Suite:	
City:	State:	Zip:

Gastroenterology:	Phone No:	
Mailing address:	Suite:	
City:	State:	Zip:

Other (specify):	Phone No:	
Mailing address:	Suite:	
City:	State:	Zip:

REASON FOR VISIT

Please describe in your own words the reason for this visit:	
Signature:	Date:

ALLERGIES

Medication:	Reaction:
1.	1.
2.	2.
3.	3.

Latex: □ Yes □ No	Tape: □ Yes □ No	Iodine: □ Yes □ No
Other:		

Continue on back of page if needed

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MEDICATIONS

1. Medication:	Dosage:
Dosage:	
2. Medication:	Dosage:
Dosage:	
3. Medication:	Dosage:
Dosage:	
4. Medication:	Dosage:
Dosage:	

Continue on back of page if needed

PAST MEDICAL HISTORY

Please answer the following as accurately as possible. If you do not understand the question, please let us know so that we can assist you. Unmarked questions will be considered as "NO" answers.

General (□ No Symptoms)

Fever?	□Yes	□No	Fatigue?	□Yes	□No
Chills?	□Yes	□No	Recent involuntary weight loss?	□Yes	□No
Night sweats?	□Yes	□No	Loss of appetite?	□Yes	□No
Explain:					

Neuropsychiatric (□ No Symptoms)

Severe headaches?	□Yes	□No	Tremors?	□Yes	□No
Dizziness?	□Yes	□No	Numbness in arms or legs?	□Yes	□No
Fainting?	□Yes	□No	Weakness in arms or legs?	□Yes	□No
Convulsions or seizures?	□Yes	□No	Pseudotumor Cerebri?	□Yes	□No
Psychiatric illness?	□Yes	□No	Eating disorder (bulimia, etc)?	□Yes	□No
Depression?	□Yes	□No	Obsessive-compulsive disorder?	□Yes	□No
Suicide attempts?	□Yes	□No	Bipolar disorder?	□Yes	□No
Explain:					

Eyes, Ears, Nose, Throat (□ No Symptoms)

Seeing double?	□Yes	□No	Sinus pain?	□Yes	□No
Blurry vision?	□Yes	□No	Recurrent sore throat?	□Yes	□No
Eye pain?	□Yes	□No	Hoarseness or weak voice?	□Yes	□No
Ringing in the ears?	□Yes	□No	Swollen glands in the neck?	□Yes	□No
Explain:					

Pulmonary (□ No Symptoms)

Wheezing (asthma)?	□Yes	□No	Pneumonia?	□Yes	□No
Chronic cough?	□Yes	□No	Tuberculosis?	□Yes	□No
Coughing up blood?	□Yes	□No	Valley fever (coccidiomycosis)?	□Yes	□No
Shortness of breath?	□Yes	□No	Problems with anesthesia?	□Yes	□No
Periods of not breathing while asleep (sleep apnea)?	□No	□CPAP	□BIPAP	□Home oxygen	
Explain:					

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Cardiovascular (□ No Symptoms)

High blood pressure?	□Yes	□No	Leg pains below the knee?	□Yes	□No
Cholesterol problems?	□Yes	□No	Skin problems on legs or feet?	□Yes	□No
Chest pain or discomfort?	□Yes	□No	Varicose veins?	□Yes	□No
Rapid or irregular heartbeat?	□Yes	□No	Leg swelling?	□Yes	□No
□ Pacemaker □ Defibrillator (AICD)			Compression stockings?	□Yes	□No
Heart murmur?	□Yes	□No	Stroke?	□Yes	□No
Heart attack (MI)?	□Yes	□No	Prior blood transfusions?	□Yes	□No
Heart failure (CHF)?	□Yes	□No	Bleeding or bruising problems?	□Yes	□No
Heart surgery?	□Yes	□No	Blood clot problems?	□Yes	□No
Explain:					

Gastrointestinal (□ No Symptoms)

Heartburn (GERD)?	□Yes	□No	Red blood in stool?	□Yes	□No
Difficulty swallowing?	□Yes	□No	Excessive gas?	□Yes	□No
Nausea or vomiting?	□Yes	□No	Trouble holding gas?	□Yes	□No
Abdominal pain?	□Yes	□No	Trouble restraining stool?	□Yes	□No
Peptic ulcers?	□Yes	□No	Colon or rectal problems?	□Yes	□No
Diarrhea?	□Yes	□No	Yellow skin or eyes (jaundice)?	□Yes	□No
Constipation?	□Yes	□No	Abnormal liver tests?	□Yes	□No
Irritable bowel syndrome?	□Yes	□No	Cirrhosis?	□Yes	□No
Change in bowel habits?	□Yes	□No	Pancreatitis?	□Yes	□No
Black or tarry stools?	□Yes	□No	Hepatitis? □No Type: □A □B □C □don't know		
Explain:					

Genitourinary (□ No Symptoms)

Burning with urination?	□Yes	□No	Urinary stream is smaller?	□Yes	□No
Pain with urination?	□Yes	□No	Bubbles in the urine?	□Yes	□No
Loss of bladder control?	□Yes	□No	Feces in the urine?	□Yes	□No
With sudden movements such as a cough or sneeze?	□Yes	□No	Blood in urine?	□Yes	□No
			Kidney failure?	□Yes	□No
Difficulty starting to urinate?	□Yes	□No	Kidney stones?	□Yes	□No
Increased urinary frequency?	□Yes	□No			
Explain:					

Endocrine / Metabolic (□ No Symptoms)

Diabetes? Type I Type II	□Yes	□No	Cannot stand heat or cold?	□Yes	□No
Abnormal fasting glucose	□Yes	□No	Hair changes?	□Yes	□No
Thyroid problems?	□Yes	□No	Excessive thirst?	□Yes	□No
Gout?	□Yes	□No			
Explain:					

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Musculoskeletal (□ No Symptoms)

Joint pain?	□Yes	□No	Problems walking?	□Yes	□No
Back pain?	□Yes	□No	Use a walker or a cane?	□Yes	□No
Bone pain?	□Yes	□No	Unable to walk 200ft (1/2 block)?	□Yes	□No
Muscles decreasing in size?	□Yes	□No	Use a wheelchair?	□Yes	□No
Arthritis (formal diagnosis)?	□Yes	□No	Difficulty getting out of bed without help?	□Yes	□No
Back surgery?	□Yes	□No			
Explain:					

Skin (□ No Symptoms)

Dry skin?	□Yes	□No	Prior skin infections?	□Yes	□No
Itching?	□Yes	□No	MRSA - Methicilin-resistant staphylococcus aureus infection?	□Yes	□No
Skin rash?	□Yes	□No			
Hanging, extra skin?	□Yes	□No	VRE - Vancomycin-resistant enterococcus infection?	□Yes	□No
with difficulty grooming?	□Yes	□No			
with difficulty walking?	□Yes	□No	Skin surgery?	□Yes	□No
Explain:					

Men's Health (□ No Symptoms)

Prostate problems?	□Yes	□No	Impotence?	□Yes	□No
Explain:					

Women's Health (□ No Symptoms)

Periods stopped for more than 6 months	□Yes	□No	Date of last PAP test?		
Menopause?	□Yes	□No	Date of last mammogram?		
Regular cycles?	□Yes	□No	Number of pregnancies/children?		
Polycystic ovarian syndrome?	□Yes	□No			
Explain:					

FAMILY HISTORY

□ Diabetes	□ Bleeding Problems	□ Obesity
□ Heart Disease (MI, Stroke, etc)	□ Cancer	□ Gallstones
□ High Blood Pressure	□ Difficulty with Anesthesia	□ Don't know - adopted

SOCIAL HISTORY

Occupation:		Marital Status: □Single □Married □Divorced □Widowed
Number of Children and Ages:		
Smoking: □Yes □No □Never	How much?	Date quit?
Alcohol: □Yes □No □Alcoholic	How much?	Date quit?
Drugs: □Yes □No	Type?	Date quit?
Caffeine: □Yes □No	Type?	Date quit?

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PREVIOUS TESTS / X-RAYS

Procedure	Date
1.	
2.	
3.	
4.	
5.	

Continue back of page if needed

PREVIOUS SURGERIES

Procedure	Date
1.	
2.	
3.	
4.	
5.	

Continue back of page if needed

PROTECTED HEALTH INFORMATION

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (THE NOTICE). THIS NOTICE PROVIDES A COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PERSONAL PROTECTED HEALTH INFORMATION (PHI).

I HAVE HAD AN OPPORTUNITY TO REVIEW THIS INFORMATION BEFORE SIGNING THIS FORM.

I GRANT MY CONSENT TO THE HOSPITAL AND/OR ANY PHYSICIAN(S) PARTICIPATING IN MY CARE, RELEASING MY PHI (EITHER IN WRITING OR VERBALLY) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. THIS INCLUDES ANY MEDICAL INFORMATION (INCLUDING DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION, PSYCHIATRIC TREATMENT INFORMATION AND HIV-RELATED INFORMATION, AS WELL AS HIV TEST RESULTS, IF APPLICABLE), WHICH MAY BE NEEDED TO PROCESS CLAIMS FOR MEDICAL INSURANCE OR MANAGED CARE BENEFITS RELATIVE TO THIS HOSPITALIZATION (INCLUDING PRE-CERTIFICATION AND VERIFICATION, IF NECESSARY) OR THAT WHICH MAY BE NEEDED TO CONDUCT CONTINUED CARE PLANNING.

SIGNATURE: **DATE:**