

NEW PATIENT WORKERS COMPENSATION INFORMATION

Patient (FULL, LEGAL) Name _____

Sex: M F

DOB: _____ Last Four Digits of SSN: _____

Marital Status: Single Married Divorced Widowed

Smoking Status: Former Never a smoker Current smoker, Packs per day _____

Social History: Occupation: _____

Alcohol: No Yes Drinks per day/week: _____

Drug Use or Addiction: No Yes Drug(s): _____ Caffeine use: No Yes How often? _____

Patient's Address: _____

Phone number: _____

Employer Name: _____

Preferred Language: _____

Have you ever been in this practice before? Yes No

Please Circle Race: Black/African American American Indian Asian White
 Hawaiian/Pacific Island Other

Please circle Ethnicity: Hispanic/Latino Not Hispanic/Latino

Date of Injury/DOI: _____

Employer Name: _____

Signature: _____ **Date:** _____

Name: _____ DOB: _____

Weight _____

Height _____

SURGERIES: YES or NO (if yes, please complete table below)

TYPE OF SURGERY	SURGERY DATE

ILLNESSES: YES or NO (if yes, please complete table below)

Illness	Date	Hospital Stay

For nurse, only: BP _____ HR _____ Temp _____ RR _____ Sat _____ Ht _____ Wt _____



PAST MEDICAL HISTORY (please check all that apply)

DOB: _____

	Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
DVT/Where?	<input type="checkbox"/>	<input type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain, where _____	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of the feet being cold	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in hands/legs/feet	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands/legs/feet	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in legs/feet	<input type="checkbox"/>	<input type="checkbox"/>

Family History: (please select all that apply)

	Father	Mother	Brother	Sister
Cancer/what type?				
Bleeding Problems				
Blood Clot				
Heart Disease				
Stroke				
High Blood Pressure				
Diabetes				
Vascular Disease				
Abdominal Aneurysm				
Stroke/TIA				



DOB: _____

ALLERGIES AND MEDICATIONS

Food Allergies: No Yes _____

Dye Allergies: No Yes _____

Shellfish/Iodine Allergies: No Yes _____

DO YOU TAKE OVER THE COUNTER OR HERBAL MEDICATIONS ON A REGULAR BASIS? YES or NO

Medication	Dosage	Frequency of Use

DO YOU TAKE PRESCRIPTION MEDICATION? YES or NO

Check here if attaching a home medication list

Medication	Dosage	Times per day	Prescribing Doctor

Preferred Pharmacy: _____ **Phone Number:** _____

Is this a mail-in pharmacy? Yes No

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I give my permission to **Surgical Specialists of Southwest Florida, P.A.**, to disclose my protected health information to the following family or friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR

I request that all my protected health information be disclosed only to "Me" and no one else other than my other healthcare providers.

May we leave a message on your answering machine/voice message about your medical care? Yes No

By signing this form, you are granting consent to Surgical Specialists of Southwest Florida to use and disclose your protected health information for purposes of treatment payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I understand that I am financially responsible for all charges of services to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for physicians' services to the physician furnishing the services.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 936-8555. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

We utilize an automated system to remind you of your next appointment. By signing this you also give us permission to include you in this automated calling system. If you do not wish to be reminded of future appointments, please let the receptionist know this.

Patient Signature: _____ Date: _____



Patient Health Questionnaire (PHQ-9)

Date of visit: _____

Patient Name: _____

DOB: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or helpless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you’re a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____ + _____

Add totals together _____

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult