The Surgical Clinic
Of Central Arkansas

INFORMATION FOR CASE HISTORY FILE

DATE: ___________ **(PLEASE COMPLETE ALL ITEMS. PLEASE PRINT)**

PATIENT INFORMATION

PATIENT'S NAME: ____ SS#:____
First Middle Last

DATE OF BIRTH: __________________ AGE: ________ GENDER: ______________

MARITAL STATUS: MARRIED SINGLE WIDOWED EMAIL: ____

HOME ADDRESS: _______________________________________ CITY: ______________________ STATE: ______ ZIP: ______________

MAILING ADDRESS: _____________________________________ CITY: ______________________ STATE: ______ ZIP: ______________

HOME PHONE: ________________________ CELL PHONE: ___________________________ ALT. PHONE: ______________________

EMPLOYER: _____________________________________ OCCUPATION: _______________________ WORK PHONE: _______________

PHARMACY NAME: ____ PHONE NUMBER: ______________________________

SPOUSE INFORMATION

NAME: ____ SS#:__________________________ D.O.B.:______________________

EMPLOYER: ____ WORK PHONE: ______________________

PARENT INFORMATION (This section applies only if the patient is a minor & the parent is financially responsible.)

NAME: ____ SS#:__________________________ D.O.B.:______________________

EMPLOYER: ____ WORK PHONE: ______________________

REFERRING DOCTOR INFORMATION

How did you find out about our clinic? ____

Referring Doctor's Name/Address: ____ Phone: ________________

Family Doctor's Name/Address: ____ Phone: ________________

EMERGENCY CONTACT INFORMATION (Please list nearest relative not living at the same address as the patient.)

Relative's Name & Address: ____

Relationship to Patient: ____ Phone: _______________________________

Patient Name: ____________________________

I hereby authorize payment directly to **The Surgical Clinic of Central Arkansas,** 9500 Kanis Rd, Suite 501, Little Rock, AR, 72205, of the medical benefits herein specified and otherwise payable to me, but not to exceed the clinic's regular charges for this period of treatment. I understand that I am financially responsible for the charges not covered by this authorization.

Authorization to Release Information: I hereby authorize **The Surgical Clinic of Central Arkansas,** and any other physicians or hospitals that have records, to release information requested by my insurance company in order to pay this claim.

Signature: ____ Date: _________________

REASON FOR APPOINTMENT: ____

Height: ____________ Weight: ____________

ALLERGIES

Please list all allergies/adverse reactions to prescription or over the counter medications, tape, x-ray contrast or dyes, etc. Please list any additional information in the space provided or on a separate page. ***Place a check in the appropriate box to indicate the type reaction.***

☐ **NO KNOWN DRUG ALLERGIES** *** ARE YOU ALLERGIC TO LATEX? YES NO**

ALLERGY	RASH	HIVES WELTS	DIFFICULTY BREATHING	ITCHING	NAUSEA VOMITING	DIARRHEA	SHOCK	IRREGULAR HEARTBEAT	OTHER REACTION

Have you ever had a bad reaction to anesthesia? Yes____ No____ If so, what type reaction?______________________________
____
____

Have you ever had a bad reaction to local anesthesia (Lidocaine, Novocain)? Yes____ No_____ If so, what type reaction?
____
____

Has a member of your family ever had a bad reaction to anesthesia? Yes____ No____ If so, what type reaction?______________
____
____

Patient Name: ______________________________

FAMILY HISTORY

Please indicate which of the following diseases are present in your family by placing ***a check in the appropriate column***.

DISEASE	MOTHER	FATHER	BROTHER	SISTER	CHILDREN
HEART ATTACK					
STROKE					
DIABETES					
HIGH BLOOD PRESSURE					
ASTHMA					
EMPHYSEMA OR BRONCHITIS (COPD)					
KIDNEY DISEASE					
HEART FAILURE					
BLOOD DISEASE					
CANCER:BREAST					
CANCER: COLON					
CANCER: OTHER					
CROHN'S DISEASE					
ULCERATIVE COLITIS					
EPILEPSY					
MENTAL DISEASE					
OBESITY					

SOCIAL HISTORY

Marital Status: (Please Circle One) Single Married Divorced Separated Widowed Domestic Partner

Diet: (Please Circle One) Regular Vegetarian Vegan Gluten-Free Low Carb Cardiac Diabetic Low Fat/Cholesterol

Caffeine Intake: (Please Circle One) None Occasional Moderate (2-6 cups daily) Heavy (6 or more cups daily)

Alcohol Intake: (Please Circle One) None Occasional Moderate Heavy

Tobacco – Cigarettes: (Please Circle One) Never Smoked Current Every Day Smoker Occasional Smoker Former Smoker

If you are or were a smoker please complete the following: _____# Packs per Day Number of Years Smoked______

Smokeless/Chewing Tobacco: Yes No ________ Times per Day Number of Years Used__________

Illicit Drugs: Yes No Type/Name: ____

Is this visit due to a work related injury? Yes No Explain: ____

Is this visit due to an automobile crash injury? Yes No Explain: ____

Do you have a Living Will? Yes No

Are you willing to accept Blood Transfusions in an emergency? Yes No

Patient Name: ______________________________

PREVIOUS SURGERY

Please list all previous surgeries in the space below or attach an additional page if needed.

PROCEDURE	DATE	HOSPITAL	SURGEON	COMPLICATIONS

PAST MEDICAL HISTORY

Please indicate which of the following you have or have had in the past by placing a check mark in the column, list any details in the blank area provided.

	Yes	Notes		Yes	Notes
Heart Failure	_______	____________________	Gallstones	_______	____________________
Heart Attack	_______	____________________	Acid Reflux/GERD	_______	____________________
Cardiac Arrhythmia	_______	____________________	Ulcers	_______	____________________
Heart Murmur or Prolapse	_______	____________________	Vomiting Blood/"Coffee Grounds"	_______	____________________
High Blood Pressure	_______	____________________	Gastroparesis	_______	____________________
Stroke	_______	____________________	Hepatitis	_______	____________________
High Cholesterol	_______	____________________	Pancreatitis	_______	____________________
Blood Disease (Leukemia)	_______	____________________	Ulcerative Colitis	_______	____________________
Blood Clots/DVT	_______	____________________	Crohn's Disease	_______	____________________
Bleeding Problems	_______	____________________	Diverticulitis	_______	____________________
COPD	_______	____________________	Hemorrhoids	_______	____________________
Tuberculosis	_______	____________________	Black or "Tarry" stool	_______	____________________
Pneumonia	_______	____________________	Rectal Prolapse	_______	____________________
Asthma	_______	____________________	Kidney Stones	_______	____________________
Sleep Apnea	_______	____________________	Kidney Failure	_______	____________________
Lung Disease	_______	____________________	Kidney Disease	_______	____________________
Thyroid Disease	_______	____________________	Cancer	_______	____________________
Diabetes: type ____	_______	____________________	Lupus	_______	____________________
Epilepsy	_______	____________________	Rheumatoid Arthritis	_______	____________________
Rheumatic Fever	_______	____________________	Osteo Arthritis	_______	____________________
Steroid Medications (Cortisone, Prednisone, ACTH) in the last 6 months	_______	____________________	Glaucoma	_______	____________________

Other Medical History not listed above: ____
____

REVIEW OF SYSTEMS **Patient Name: ______________________________**

Please place a check in the box to indicate which of the following you have had in the last year.

General:

☐ **Weight loss**	☐ **Fatigue**	☐ **Fever**	☐ **No Problem**
☐ **Weight gain**	☐ **Weakness**	☐ **Night Sweats**	

Skin:

☐ **Rashes**	☐ **Moles**	☐ **Ulcers/Sores**	☐ **No Problem**
☐ **Dryness**	☐ **Changes in skin/hair/nails**		

Eyes:

☐ **Blurring Vision**	☐ **Pain**	☐ **Dryness**	☐ **No Problem**
☐ **Flashes of Light**	☐ **Vision Halos**	☐ **Glasses**	
☐ **Contacts**	☐ **Blindness (Circle One): Right Left Both**		

Ears:

☐ **Drainage**	☐ **Ringing**	☐ **Earache**	☐ **No Problem**
☐ **Hearing Aide**	☐ **Hearing Loss (Circle One): Right Left Both**		

Nose:

☐ **Nosebleeds**	☐ **Sinus Pain**	☐ **Congestion**	☐ **No Problem**
☐ **Deviated Septum**	☐ **Post Nasal Drip**		

Mouth:

☐ **Sore Throat**	☐ **Bleeding Gums**	☐ **Teeth Problems**	☐ **No Problem**
☐ **Dry Mouth**	☐ **Snoring**	☐ **Dentures**	

Throat:

☐ **Trouble Swallowing**	☐ **Hoarseness**	☐ **Lump/Masses**	☐ **No Problems**

Heart & Circulation:

☐ **Chest Pain/Pressure**	☐ **Irregular Heartbeat**	☐ **Lightheadedness**	☐ **No Problem**
☐ **Fast/Slow Heart rate**	☐ **Ankle Swelling**	☐ **Fainting Spells**	
☐ **Low Blood Pressure**			

Lungs:

☐ **Shortness of Breath**	☐ **Wheezing**	☐ **Cough**	☐ **No Problem**
☐ **Coughing up Blood**	☐ **Pleurisy**	☐ **Asthma**	
☐ **Pneumonia**	☐ **Phlegm/Sputum**		

Patient Name: ____________________________________

Stomach & Intestines:

- ☐ Abdominal Pain ☐ Indigestion ☐ Vomiting ☐ No Problem
- ☐ Change in appetite ☐ Nausea ☐ Diarrhea
- ☐ Constipation ☐ Rectal Bleeding ☐ Vomiting Blood
- ☐ Black/Tarry Stool ☐ Hemorrhoids ☐ Change in Bowel Habits

Urinary:

- ☐ Incontinence ☐ Blood in Urine ☐ Painful Urination ☐ No Problem
- ☐ Pus in Urine ☐ Enlarged Prostate ☐ Increase Urinary Frequency

Falls Risk Assessment:

- ☐ Imbalance ☐ 2 or more falls in past year ☐ No Problem

Nervous System:

- ☐ Tingling of Body Parts ☐ Seizures ☐ Tremors ☐ No Problem
- ☐ Headaches ☐ Migraines ☐ Restless Legs
- ☐ Weakness ☐ Numbness (Circle One): Right Left

Hormones:

- ☐ Heat Intolerance ☐ Cold Intolerance ☐Hair Loss ☐ No Problem
- ☐ Excessive Thirst/Hunger

Blood:

- ☐ Easy Bruising/Bleeding ☐ Clotting Problems ☐ Anemia ☐ No Problems
- ☐ Enlarged Lymph Nodes

Psychological:

- ☐ Loss of Interest ☐ Depression ☐ Difficulty Sleeping ☐ No Problems
- ☐ Nervousness/Anxiety ☐ Alcohol/Drug Abuse ☐ Difficulty Concentrating

Genitals:

- ☐ Erectile Difficulties ☐ Sores ☐ Hernias ☐ No Problems
- ☐ Testicular Pain/Mass ☐ Groin Swelling ☐ Breast Lumps
- ☐ Irregular Periods ☐ Painful Periods ☐ Vaginal Discharge
- ☐ Painful Intercourse ☐ Bleeding Between Periods

____ __________ ____________________________________

Patient Signature **Date** **Physician Signature**

Patient Name: ____________________________________

Dear Patients,

Our office is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients.

As a part of this program, the government requires us to record the following demographic information about you:

•Preferred language •Date of Birth •Gender •Race •Ethnicity

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential.

You can help us by reviewing the list of options below and providing your race and ethnicity information during check in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

The Surgical Clinic of Central Arkansas

Please indicate your preferred language: ___________________________________

Please identify your race from the following CDC – defined options:

- ☐ African
- ☐ American Indian
- ☐ Arab
- ☐ Asian
- ☐ Black or African American
- ☐ Cambodian
- ☐ Chinese
- ☐ European
- ☐ Pilipino
- ☐ Haitian
- ☐ Indonesian
- ☐ Jamaican
- ☐ Thai
- ☐ Japanese
- ☐ Korean
- ☐ Middle Eastern
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Polynesian
- ☐ Vietnamese
- ☐ West Indian
- ☐ White

- ☐ Other: ____________________________

Please identify your Ethnicity from the following CDC- defined options:

- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino/Spanish
- ☐ Latin American/Latin/Latino
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

Patient Name: ___________________________

MEDICATIONS

Please list all prescription and over the counter medications, vitamins, or herbal supplements.

MEDICATION	DOSAGE	FREQUENCY	USED FOR

I agree that The Surgical Clinic of Central Arkansas may request and use my prescription medication history from other healthcare providers or Third Party pharmacy benefit payers for treatment purposes.

____

Signature of Patient or Guardian Date

I give my consent to receive automated phone calls from The Surgical Clinic of Central Arkansas on my mobile phone.

____

Signature of Patient or Guardian Date