U WELLNESS SURGICAL

NEW PATIENT REGISTRATION

Date _____ Patient Name _____ Date of Birth _____

Age _____ Gender _____ Marital Status _____

SSN _____ Preferred Language _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ Zip _____

Patient's Employer _____

PATIENT INSURANCE INFORMATION

Primary Insurance Carrier _____ DOB of Insured _____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance Carrier _____ DOB of Insured _____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

If patient is a Minor, are parents ☐ Married, ☐ Divorced? Custodial Parent_____

Custodial Parent's Phone: (_____) _____ -- _____

Custodial Parent's SS #: _____ Date of Birth_____

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name _____ City _____

Primary Care Physician _____ City _____

EMERGENCY CONTACT INFORMATION

Name _____Relationship to Patient _____Phone _____

Reason for visit:_____

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Medication List

Medication Name	Dosage	Frequency

____ See Attached

Vaccinations: Pneumonia ____ COVID ____ Gardasil (HPV) ____

Preferred Pharmacy: _____
Pharmacy Address: _____
Pharmacy City:_____

Allergies

Medication Allergy	Reactions

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MEDICAL HISTORY

Please circle any problem YOU have had or are being treated for.

ANAL/RECTAL

Hemorrhoids
Fissure
Fistula
Abscess

GASTROINTESTINAL

Accidental bowel leakage
Celiac disease (gluten sensitivity)
Colon/Rectal polyps
Crohn's disease
IBS (Irritable bowel syndrome)
Ulcerative colitis

CANCER

Anal cancer
Bladder cancer
Breast cancer
Cervical cancer
Colon cancer
Kidney cancer
Ovarian cancer
Penile cancer
Prostate cancer
Rectal cancer
Small bowel cancer
Stomach cancer
Uterine cancer
Other cancer:

BLOOD PROBLEMS

Anemia
Blood clots (DVT/Embolism)
Bleeding disorder
Clotting disorder

ENDOCRINE

Diabetes
Hyperthyroidism (high thyroid disease)
Hypothyroidism (low thyroid disease)
Uterine Endometriosis

KIDNEY/URINARY

Poor kidney function
Renal failure
Urinary incontinence (leakage of urine)
Kidney stones

NEUROLOGICAL

Stroke
Neuropathy

RESPIRATORY

Asthma
COPD/Emphysema

CARDIOVASCULAR

Angina (chest pain)
Arrhythmia (heart rhythm problems)
Heart failure
Hyperlipidemia high cholesterol)
Hypertension thigh blood pressure)
Malignant hyperthermia
Past heart attack
Peripheral vascular disease: (blood vessel problems in legs)

EYES

Glaucoma
Vision loss

MENTAL HEALTH

Anxiety
Depression

MUSCULOSKELETAL

Arthritis
Back problems
Gout

INFECTIONS

Hepatitis
HIV
HPV

Other not Listed:_____

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SURGICAL HISTORY

Surgery	Date

Last Colonoscopy: _____ Last Endoscopy _____

ALCOHOL USE

Do you drink alcohol? YES☐ NOT CURRENTLY☐ NEVER☐
If yes, how often? Daily☐ Weekly☐ Monthly☐ Socially☐ Rarely☐
AMOUNT consumed: Glasses of wine____ Cans of beer____ Shots of liquor____ Drinks containing 0.5 oz of alcohol____

TOBACCO USE

Smoking: Never☐ Former☐ Every Day☐ Some Days☐ Passive Exposure: Never☐ Past☐ Current☐
Smokeless tobacco: Never☐ Past☐ Current☐
Types: Cigarettes☐ Vaping☐ Cigar☐ Pipe☐ Chew☐ Snuff☐
Smoked from (year) _____ - _____ Packs per day:_____

DRUG USE

Do you use recreational drugs? YES☐ NOT CURRENTLY☐ NEVER☐
If yes, please list._____
Have you in the past? YES☐ NO☐
Have you ever used intravenous drugs? YES☐ NO☐

SEXUAL ACTIVITY

Sexually active: YES☐ NOT CURRENTLY☐ NEVER☐
Type of birth control/protection: _____
Partners: Female☐ Male☐

CAFFEINE USE

Please circle all that apply: Coffee☐ Soda☐ Tea☐ Chocolate☐ Other☐ Number of cups:_____(daily/weekly/monthly)

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FAMILY HISTORY

	Family Member	Maternal (M) or Paternal (P)	Comments
Anxiety/Depression			
Arthritis			
Asthma			
Breast Cancer			
Clotting Disorder			
Colon/Rectal Cancer			
COPD			
Crohn's/Ulcerative Colitis			
Dementia			
Diabetes			
Glaucoma			
Heart Disease			
Hyperlipidemia (high cholesterol)			
Hypertension (high blood pressure)			
Kidney Disease			
Lung Cancer			
Migraines			
Osteoporosis			
Ovarian Cancer			
Prostate Cancer			
Stroke			
Thyroid Disease			
Uterine Endometrial			
Other.			