



**NORTH  
INDY  
SURGICAL**

Drs Davis, Arregui, Singh and Mathavan  
**Patient Information Form**

**Phone: 317-872-1158**

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**Appt Date** \_\_\_\_\_ **Arregui**  **Davis**  **Singh**  **Mathavan**

**DEMOGRAPHICS**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Gender \_\_\_\_\_  
SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_  
Street \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Employer \_\_\_\_\_  
Cell# \_\_\_\_\_ Email: \_\_\_\_\_

**INSURANCE**

<b>Primary</b>	<b>Secondary</b>	<b>Other</b>
Carrier _____	Carrier _____	Carrier _____
ID# _____	ID# _____	ID# _____
Group # _____	Group # _____	Group # _____

**EMERGENCY CONTACT**

#1 Last Name _____	First Name _____	Relationship _____
Home Phone _____	Work Phone _____	Cell/Pager# _____
#2 Last Name _____	First Name _____	Relationship _____
Home Phone _____	Work Phone _____	Cell/Pager# _____

**PHYSICIANS**

<b>REFERRING</b>	<b>FAMILY</b>	<b>CARDIOLOGIST</b>
Last Name _____	Last Name _____	Last Name _____
First Name _____	First Name _____	First Name _____
Office Phone# _____	Office Phone# _____	Office Phone# _____

<b>OTHER</b>	<b>OTHER</b>	<b>OTHER</b>
Last Name _____	Last Name _____	Last Name _____
First Name _____	First Name _____	First Name _____
Office Phone# _____	Office Phone# _____	Office Phone# _____

**PREVIOUS SURGERIES & PROCEDURES**

TYPE OF SURGERY/YEAR OF SURGERY

TYPE OF SURGERY/YEAR OF SURGERY

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_

6 \_\_\_\_\_  
7 \_\_\_\_\_  
8 \_\_\_\_\_  
9 \_\_\_\_\_  
10 \_\_\_\_\_

**Tobacco Use (Circle all that apply)**

Do You Smoke or Chew Tobacco: YES or NO \_\_\_\_\_ When did you quit smoking: \_\_\_\_\_  
If yes or if you quit, how many pks per day: \_\_\_\_\_  
How many years did you or have you smoked: \_\_\_\_\_

**ALCOHOL USE (CHECK WHICH APPLIES)**

Daily \_\_\_\_\_ Occ. \_\_\_\_\_ Heavy \_\_\_\_\_ Socially \_\_\_\_\_ Never \_\_\_\_\_

**PAST MEDICAL HISTORY**

CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY & DESCRIBE THE CONDITION

Heart Disease \_\_\_\_\_  
Pacemaker or Defibrillator \_\_\_\_\_  
Lung Problems or Asthma \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Colon or Bowel \_\_\_\_\_  
Cancer \_\_\_\_\_  
Stroke or Mini Stroke \_\_\_\_\_  
Bleeding Tendencies \_\_\_\_\_  
Blood Clots or Cellulitis \_\_\_\_\_  
Others (please list) \_\_\_\_\_

**PRESCRIPTION MEDICATIONS**

Medication	Dose/Frequency
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

Medication	Dose/Frequency
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____
11 _____	_____
12 _____	_____

**NON-PRESCRIPTION MEDICATIONS**

**OVER-THE-COUNTER (INCLUDING ASPIRIN)**

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

**HERBAL PREPARATIONS & DIETARY SUPPLEMENTS**

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

**ARE YOU ALLERGIC TO ANY MEDICATIONS, FOODS OR PRODUCTS?**

**WHAT TYPE OF REACTION?**

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

7 _____
8 _____
9 _____
10 _____
11 _____
12 _____

**FAMILY MEDICAL HISTORY (Do any family members, alive or deceased, have medical problems?)**

1 _____
2 _____
3 _____
4 _____

5 _____
6 _____
7 _____
8 _____

## REVIEW OF SYSTEMS

(Check any of the following you currently experience)

### General

Weight Loss  
Weight Gain  
Fever  
Fatigue

### Eyes

Pain  
Discharge  
Light Sensitivity  
Blurred Vision

### ENT

Sore Throat  
Hoarseness  
Ear Ringing  
Nose Bleeds

### Respiratory

Wheezing  
Cough  
Shortness of breath  
Chest Congestion

### Cardiovascular

Chest Pain  
Fainting  
Swelling of feet  
Palpitations  
Swelling of hands

### Genitourinary

Painful Urination  
Hesitancy  
Urgency  
Blood in urine  
Flank Pain

### Neurological

Headache  
Confusion  
Numbness  
Slurred Speech  
Dizziness/Vertigo  
Extremity Weakness  
Extremity Paralysis

### Musculoskeletal

Joint Swelling  
Joint Pain  
Back Pain  
Muscle Cramps  
Muscle Weakness

### Skin

Rash  
Itching  
Sores  
Abscess  
Discharge

### Endocrine

Excessive Sweating  
Excessive Thirst  
Heat Intolerance  
Excessive Urination  
Excessive Hunger

### Hematologic/Lymph

Lymph node swelling  
Easy Bruising  
Bleeding  
Skin Discoloration

### Allergic/Immunologic

Seasonal Allergies  
Hives  
Persistent Infections

### Psychologic

Anxiety  
Depression  
Severe Stress  
Panic Attacks

### Gastrointestinal

Abdomen pain  
Unusual belching  
Nausea  
Vomiting  
Diarrhea  
Constipation  
Blood in stool  
Dark, tarry stool  
Bloating  
Change in bowel habits  
Indigestion  
Excessive Gas  
Difficulty Swallowing  
Yellow Skin Color

### History of the following:

MRSA  
VRE

**HEIGHT** \_\_\_\_\_

**WEIGHT** \_\_\_\_\_