Nagan, Arregui & Davis, MD's, Inc. DBA North Indy Surgical

Patient Information Form

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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

Primary		**Secondary**		**Other**	
Carrier	_____	Carrier	_____	Carrier	_____
ID#	_____	ID#	_____	ID#	_____
Group #	_____	Group #	_____	Group #	_____

EMERGENCY CONTACT

#1Last Name _____ First Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell/Pager# _____

#2 Last Name _____ First Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell/Pager# _____

PHYSICIANS

REFERRING		**FAMILY**		**CARDIOLOGIST**	
Last Name	_____	Last Name	_____	Last Name	_____
First Name	_____	First Name	_____	First Name	_____
Office Phone#	_____	Office Phone#	_____	Office Phone#	_____

OTHER		**OTHER**		**OTHER**	
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	6
2	7
3	8
4	9
5	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		Make/Model#/Serial#
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	Medication	Dose/Frequency
1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

NON-PRESCRIPTION MEDICATIONS

OVER-THE-COUNTER (INCLUDING ASPIRIN)	HERBAL PREPARATIONS & DIETARY SUPPLEMENTS
1	1
2	2
3	3
4	4
5	5
6	6

ARE YOU ALLERGIC TO ANY MEDICATIONS, FOODS OR PRODUCTS?	WHAT TYPE OF REACTION?
1	7
2	8
3	9
4	10
5	11
6	12

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

1	5
2	6
3	7
4	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** _____