GREENVILLE HEALTH SYSTEM

## Patient Information

**(Please print)**

Full Legal Name: ____________________ Preferred Name: ____________
*Last* *First* *Middle*

Sex: ☐ Male ☐ Female

Date of Birth: ____________ SS#: ____________
*Month/Day/Complete Year*

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refuse/Decline ☐

Primary Care Physician:____________

Preferred Pharmacy Name:____________Phone Number:____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated

Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (black) ☐ Hispanic ☐ Biracial ☐ Asian Oriental ☐ Other ☐ Unknown

Home Address:____________ City:____________ State: ______Zip: ______

Mail to Address: ____________ City:____________ State: ______Zip: ______

County:____________ Home Phone: ( )____________ Cell Phone: ( )____________

Preferred language: ____________ E-mail: ____________

Veteran: ___Yes ___No ___Unknown Religion: ____________

**Guarantor Information** *(If guarantor is Self, skip to Emergency Contact)*

**Parent/guardian** presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: ____________ Patient relation to Guarantor: ____________
*Last* *First* *Middle*

Home Phone: ( )____________

Date of Birth: ____________ SS#: ____________ Cell Phone: ( )____________

Home Address:____________City: ______ State:______Zip: ______ Country: ______

Mail to Address *(if different)*: ____________City: ______ State:______Zip: ______ Country: ______

**Emergency Contact** *(Pediatric Patients please list someone other than parent(s)/guardian)*

Primary Contact Name: ____________ Home Phone: ( ) ____________

Patient Relation to Emergency Contact ____________ Cell Phone: ( )____________

Secondary Contact Name: ____________ Home Phone: ( ) ____________

Patient Relation to Emergency Contact ____________ Cell Phone: ( )____________

### Employment

**Patient Employer:** ____________ **Work Phone:**____________ **Ext:** ______

**Address:** ____________ **City:**____________ **State:** ______**Zip:**______

**Employment Status:** ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time** ☐ **Student Part-Time** ☐ **Retired Date** ______ ☐ **Disabled** ☐ **Not Employed** ☐ **Unknown**

**(Pediatric Patients Only) Parent/Guardian & Immediate Family Information**

**Mother** *(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)*

Full Name: ____________ Nickname: ____________
*Last* *First* *Middle*

Date of Birth: ____________
*Month / Day / Complete Year*

SS#: ____________

Home Address:____________ City:____________ State: ______Zip: ______
(if different from patient)

Home Phone:____________ Cell Phone: ( ) ____________

Employer:____________ Work Phone: ( ) ____________ Ext:______

**Father** *(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)*

Full Name: ____________ Nickname: ____________
*Last* *First* *Middle*

Date of Birth: ____________
*Month / Day / Complete Year*

SS#: ____________

Home Address:____________ City:____________ State: ______Zip: ______
(if different from patient)

Home Phone:____________ Cell Phone: ( ) ____________

Employer:____________ Work Phone: ( ) ____________ Ext:______

Patient Name ________________________________________ DOB ________________________________

**(Pediatric Patients Only) Brothers, Sisters & Other Family Members**

| *Full Name* | *M or F* | *Date of Birth* | *Relationship* | *Lives with child* |
|---|---|---|---|---|
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |

☐ **Check here if no insurance. And, skip to Authorization (below).**

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**Accident Information**

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ Yes ☐ No

Type of Accident: ____________________ Date of Accident:______________ County of Accident: ______________

**Primary Insurance Information**

**Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.**

Subscriber's Name on card: ________________________________________ Date of Birth: ________________
*Month / Day / Complete Year*

Patient Relationship to Subscriber: ____________________ Sex: ☐ Male ☐ Female

**If address and phone number is same as patient, please indicate same.**

Address: ________________________________________ SS#: ______________________

City, State, Zip: ________________________________________ Home Phone:______________________

Employer: ____________________________________ Work Phone: ________________ Ext.______

**Insurance Co. Name:** ________________________________________ **Phone:** ______________________

**Policy/Cert #:**____________________**Group No:** ____________ **Effective Date:**________________

**Subscriber Status:** ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time**
☐ **Student Part-Time** ☐ **Retired Date** ______ ☐ **Disabled** ☐ **Not Employed**

**Secondary Insurance Information**

**SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.**

Subscriber's Name on card: ________________________________________ Date of Birth: ________________
*Month / Day / Complete Year*

Patient Relationship to Subscriber: ____________________ Sex: ☐ Male ☐ Female

**If address and phone number is same as patient, please indicate same.**

Address: ________________________________________ SS#: ______________________

City, State, Zip: ________________________________________ Home Phone:______________________

Employer: ____________________________________ Work Phone: ________________ Ext.______

**Insurance Co. Name:** ________________________________________ **Phone:** ______________________

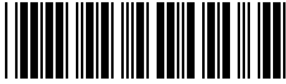
**Policy/Cert #:**____________________**Group No:** ____________ **Effective Date:**________________

**Subscriber Status:** ☐ **Full-Time** ☐ **Part-Time** ☐ **Self Employed** ☐ **Active Military** ☐ **Student Full Time**
☐ **Student Part-Time** ☐ **Retired Date** ______ ☐ **Disabled** ☐ **Not Employed**

**Authorization**

*I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.*

**Signature of Patient/Guardian/Guarantor:** ________________________________________ **Date:**______________



# AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

**THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF GREENVILLE HEALTH SYSTEM UNLESS REVOKED OR MODIFIED BY THE PATIENT IN WRITING.**

Patient Name (PRINT) ________________________________________________

DOB ________________

(For Office Use Only)
MRN_________________________

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?** (*Check and complete one*)

☐ The following family members or other individuals may receive information regarding my medical condition:
*Print first and last name(s)*____________________________________________________________

______________________________________________________________________________

**OR**

☐ Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)*________________________________

______________________________________________________________________________

**You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.**

***NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.***

**Confidential Communication:** Please provide phone number(s) where we can reach you:
☐ Home:______________ ☐ Work:______________ ☐ Cell Phone:______________ ☐ Other________________

**Messages:** A request for return calls may be left on the following answering machine or voice mail: (*Check all that apply*)
☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: (*Check all that apply*)
☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

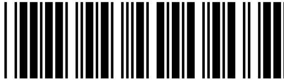
If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name ____________________________ Phone Number ________________________
Name____________________________ Phone Number ________________________

Note: *An automated appointment reminder system may call the number listed in our data base.*

**Signature:** I hereby authorize the disclosure of my medical condition and information as described above.
Patient/Patient's Representative Signature:_______________________________________ Date: _______Time:______
PRINT Name (if Patient's Representative): _______________________________________
Relationship to Patient (if Patient's Representative):_________________________________

GHS Representative:____________________________________________Date: ____________ Time:____________
Form Create Date: December 30, 2013



Consents/Registration
Greenville Health System

# CONSENT AND AUTHORIZATION - UMG

The following are conditions for services provided by the Greenville Health System (GHS) for the above-named patient :

**CONSENT AND AUTHORIZATION FOR ROUTINE TREATMENT:** I consent to and authorize GHS and my health care providers to provide or order routine health care services, including diagnostic and laboratory procedures that in the judgment of my provider(s), are necessary. Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment. Diagnostic/laboratory procedures that may be ordered could include testing for HIV, Hepatitis, and other diseases categorized as sexually transmissible diseases. I can tell my provider if I do not want to be tested for any and all of these diseases. If test results are positive, they will be shared with me.

**PHYSICIANS:** I understand that physicians who are members of the GHS medical staff and who practice in GHS facilities may not be employees or agents of GHS. I understand that GHS is not responsible for any act or omission by a physician who is not an employee or agent of GHS. I understand GHS is a medical teaching institution and that students and residents may be involved in my care with required/appropriate supervision.

**TELEMEDICINE:** Health care services may be provided via telemedicine which involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, medical images, live two-way audio and video, Output data from medical devices and sound and video files. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption

**ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS:** If my account is not paid at the time of my visit, I hereby assign to GHS any and all rights, including proceeds, I may have from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of GHS), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to physician(s) not employed by GHS, any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at GHS (such as anesthesiologists, pathologists, and other private physicians).I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. I understand that I am responsible for any charges not covered by insurance, including Medicare, Medicaid, or any other benefits. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I hereby authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate GHS as my authorized representative and grant to GHS the authority to act on my behalf in pursuing and appealing a benefit determination under the plan, including Medicare and Medicaid. Such authority shall include the right to request and receive a copy and/or summary of the plan description.

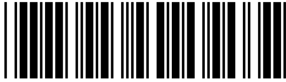
**FINANCIAL AGREEMENT:** I understand that I am obligated to pay my account according to the regular rates and terms of GHS, except for those services provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. If the benefits received by GHS exceed the charges on my account, I authorize GHS to apply the over-payment to my other outstanding account(s) with GHS or GHS entities, which include GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity that is or becomes a part of GHS. If there is no other outstanding account for which I am responsible, the payment will be posted to the intended account and a refund processed accordingly. I understand that GHS may obtain my credit report for review in collection of this account. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

**MEDICARE PATIENTS:** Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

**CONTACTING PATIENTS:** I hereby authorize GHS to contact me through the information provided at the time of registration. I hereby consent to receive autodialed and/or pre-recorded calls regarding my outstanding balance, if any, from or on behalf of GHS and/or GHS Partners in Health, Inc. at the telephone number(s) that I have provided to GHS and/or GHS Partners in Health, Inc.

**DISCLOSURE/USE OF HEALTH INFORMATION:** I understand that uses and disclosures of my personal and health information are described in the GHS Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I understand that my personal and health information will be made available to providers through the GHS Health Information Exchange as described in the Notice of Privacy Practice. I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

**HEALTHCARE ASSOCIATED INFECTIONS:** Healthcare- associated infections can be a complication of hospitalization. South Carolina has a public reporting law: Hospital Infections Disclosure Act, S.C. code Ann. Section 44-7-2410, which requires hospitals to monitor and report targeted healthcare associated infections to the Department of Health and Environmental Control (DHEC). These reports are available on the following website for public view: http://www.scdhec.gov/Health/FHPF/InfectionControlHIDA/HospitalInfectionControl/



Consents/Registration
Greenville Health System

**CONSENT AND AUTHORIZATION - UMG**

PHOTOGRAPHING: I consent to GHS taking photographs for purposes of identification, diagnosis, treatment, education, and research. Photographs that could identify me will be used only for internal medical record identification purposes unless I specifically agree and sign an additional consent document.

**CONDITIONS FOR CARE; ALTERATIONS VOID: I understand that the above are conditions for care and treatment at GHS. Any alterations to the content of any of the conditions above are void and will not change the conditions as stated. I understand that by signing this form, or receiving care or treatment at GHS, I agree to the contents of this Consent and Authorization in its "as is" form.**

SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE ___________________________________

PRINTED NAME AND RELATIONSHIP IF OTHER THAN PATIENT _________________________________________

DATE __________ TIME _______________

SIGNATURE OF WITNESS ___________________________ DATE ______________ TIME_____________________

SIGNATURE OF WITNESS ___________________________ DATE ______________ TIME _____________________
(SECOND WITNESS FOR TELEPHONE CONSENT OR SIGNATURE WITH "X" OR MARK)

**CHART COPY**

GREENVILLE HEALTH SYSTEM

## Financial Policy

**Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.**

The following are the conditions for services provided to the patient by Greenville Health System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Health System or GHS.

**Payment for Service:** Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

**Method of Payment:** You may pay your bill with cash, personal check, certain credit cards, or debit card.

**Returned Checks:** A $25.00 service charge will be added on all checks returned to us for insufficient funds.

**Non-appointment Prescription Refills:** A $15.00 charge per incidence may be added for non-appointment prescription refills.

**Non-appointment Prescription:** A $25.00 charge may be billed to you for new prescriptions filled via phone.

**Completion of Medical Forms:** There may be a charge for completion of forms such as disability, camp physicals, etc.

**Copies of Medical Records:** There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $25.00
- Plus actual postage

**No-show Appointments:** A fee of $25.00 for a follow up visit and $50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not canceled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

**Payment for Services Provided by Certain Providers:** If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as GHS University Medical Group, you may be billed separately by that service provider. This includes services provided by Greenville Health System.

**Collection Policy:** Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-454-2000 or 1-888-284-6024 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

**Questions:** We are here to help should you have any questions regarding your statement or insurance.

# Patient History Questionnaire-Adult

**(All information will remain confidential)**

**Can the Surgery Dept. leave a message on your phone related to your surgery ? ☐ Yes ☐ No**

| | | | | |
|---|---|---|---|---|
| Patient name: | Date of Birth: / / | Male ☐ Female | Date: | Time: |
| | | | | |
| Home Phone: | Cell Phone: | Work Phone: | | |
| Height: Weight: | Primary Language: ☐ English ☐ Spanish ☐ Other: | | | |
| Primary Care Physician: | Cardiologist: | Date Last Seen? | | |
| Other Physician: | Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No | | | |
| Name of person driving you home? | Relationship: | Phone: | | |

| **Do you have any allergies to any of the following?** | **Yes** | **No** | **Unknown** | **Reaction** |
|---|---|---|---|---|
| Foods (banana, kiwi, avocado, tomato) | | | | |
| Latex (sneakers, balloons, rubber) | | | | |
| | | | | |
| **Allergies:** | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Medications that you are currently taking:** (May list on a separate sheet, please give reactions) | | | | |
| **Drug: Dose: How Often:** | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Anesthesia:** | **Yes** | **No** | **Unknown** | **Explain** |
| Have you ever had anesthesia? | | | | |
| Have you ever had a problem with anesthesia including Malignant hyperthermia or difficult intubation? | | | | |
| Has any member of your family had a breathing problem with Anesthesia? | | | | |
| Loose, capped or broken teeth; bridges or dentures? | | | | |
| Do you exercise regularly? | | | | Low/moderate/active |
| Do you have shortness of breath after walking up 2 flights of stairs? | | | | |
| Do you smoke? | | | | #packs/day___# years___ |
| Are you an ex-smoker? When did you stop? | | | | |
| Do you drink alcoholic beverages? What kind? _______ | | | | How much_____ how often____ |
| Do you use street drugs? | | | | |
| Have you ever had a blood transfusion? | | | | If 'yes', what year(s)___ |
| Do you have objections to receiving blood transfusions? | | | | |
| Do you have problems with chronic pain? | | | | |
| **Female:** Any chance of you being pregnant?<br>Number of Births? _____________<br>Last Menstrual Period:_____________ | | | | |

| **Please list all hospitalizations and explain.** |
|---|
| |

90276 D R S 10

# Patient History Questionnaire-Adult

Patient Name:

| **Respiratory (Lungs)** | ☐ Dementia | ☐ Nausea and Vomiting | ☐ Arthritis |
|---|---|---|---|
| ☐ Asthma | ☐ Headaches | ☐ Stomach Cancer | ☐ Back Injury☐ |
| ☐ Bronchitis☐ | ☐ Hydrocephalus | ☐ Stomach Ulcer☐ | ☐ Back Pain |
| ☐ COPD | ☐ Migraines | **Renal/ Reproductive** | ☐ Gout |
| ☐ Emphysema | ☐ Neural Tube Defect | ☐ Abnormal Pap Smear☐ | ☐ ☐ Mobility Impairment |
| ☐ Lung Cancer | ☐ Neuropathy | ☐ Bladder Incontinence | ☐ Paralyzed |
| ☐ Pulmonary FB | ☐ Fibromyalgia | ☐ Cancer of the kidney | ☐ Rheumatoid Arthritis |
| ☐ Upper Respiratory Inf | ☐ ☐ Scotoma NOS | ☐ Cancer of the prostate | ☐ Scoliosis |
| ☐ Seasonal Allergies | ☐ Seizures | | |
| ☐ Smoker | ☐ Stroke | ☐ Chronic kidney disease | **Psycosocial** |
| | | ☐ Congenital Uterine Birth defect | ☐ ETOH (alcohol dependent) |
| **Cardiac (Heart)** | **Gastrointestinal (Stomach)** | ☐ Dysmenorrhea (abnormal bleeding) | ☐ Anxiety |
| ☐ Anemia | ☐ Chronic Constipation | ☐ Infertility☐ | ☐ Bi-polar |
| ☐ Arrhythmia | ☐ Chronic Diarrhea | ☐ Kidney Stones | ☐ Depression |
| ☐ CHF | ☐ Crohns Disease | ☐ Pyelonephritis | ☐ Drug Dependence |
| ☐ Congenital Defect | ☐ Dysphasia | ☐ Stress Incontinence | ☐ Mental Illness |
| ☐ Heart Disease | ☐ Epigastric Pain | ☐ Urinary Frequency | ☐ Panic Attacks |
| ☐ Heart Murmur | ☐ Esophagus Cancer | ☐ Urinary Urgency☐ | **Infection History** |
| ☐ Heart Valve Disease | ☐ GERD | **Endocrine** | ☐ HIV |
| ☐ High Cholesterol | ☐ GI Bleed | ☐ Autoimmune Disorder | ☐ MRSA |
| ☐ High Blood Pressure | ☐ Hemorrhoids | ☐ Diabetes-Insulin Dep. | ☐ TB – Tuberculosis |
| ☐ Irregular Heart Beat☐ | ☐ Hepatitis☐ | ☐ Diabetes-Not Insulin | ☐ VRE |
| ☐ MI (Heart Attack) | ☐ Hepatitis A | ☐ Diabetes –Type 1 | ☐ C-Diff |
| ☐ Phlebitis | ☐ Hepatitis B | ☐ Diabetes- Type 2 | |
| ☐ Peripheral Vascular Dis | ☐ Hepatitis C | ☐ Hyperthyroidism | **Pregnancy** |
| ☐ Sickle Cell Anemia | ☐ Hiatal Hernia | ☐ Hypothyroidism | ☐ Pre-eclampsia |
| ☐ Stents | ☐ Hyperemesis | ☐ Pancreatitis | ☐ Gestational Diabetes |
| ☐ Varicose Veins | ☐ Irritable Bowel | | ☐ Gestational HTN |
| | ☐ Liver Disease | **Musculoskeletal** | ☐ Rh Negative |
| | ☐ Nausea | ☐ AboveKneeAmputation | ☐ Pre-Term Labor |
| **Neurological** | | ☐ BelowKneeAmputation | ☐ C-Sections |
| ☐ Alzheimer's Disease | **Skin** | | ☐ Incomplete Cervix |
| ☐ Cataracts | ☐ No open wounds | | |
| ☐ Glasses | | **Implants** | ☐ Term Pregnancy |
| ☐ Hearing Loss / Aids | | ☐ List | ☐ Sexual Disease |

## Surgical History: (Check all that apply)

| | | | | |
|---|---|---|---|---|
| ☐ **No Prior Surgery** | ☐ Cataract | ☐ Hemorrhoidectomy | ☐ Prostate | ☐ Tubal Ligation |
| ☐ Angioplasty | ☐ D and C | ☐ Hernia | ☐ Spine (Back/Neck) | List any other: |
| ☐ Appendectomy | ☐ Gallbladder | ☐ Hysterectomy | ☐ Splenectomy | ___________________ |
| ☐ Arthroscopy | ☐ Heart Cath | ☐ Kidney removal | ☐ Tonsils and Adenoids | ___________________ |
| ☐ Breast Biopsy | ☐ Heart Valve replaced | ☐ Mastectomy Left/Right | ☐ Total Hip Left / Right | ___________________ |
| ☐ Heart Bypass | | ☐ Pacemaker | ☐ Total Knee Left/Right | |

## Family History (close blood relatives): (Check all that apply)

| | | | | |
|---|---|---|---|---|
| ☐ Heart disease | ☐ Diabetes | ☐ Cancer | ☐ Thyroid disease | ☐ Neurological |
| ☐ High Blood Pressure | ☐ Tuberculosis | ☐ Kidney disease | ☐ Blood disease | ☐ Mental Illness |

**List any Religious or cultural practices we should know about while caring for you:**

Patient or Patient Representative Signature: Relationship: Date: Time:

Pre-Admission Screen Reviewer: , RN Date: Time:

90276 DRS10