BENRUS SURGICAL ASSOCIATES

At Barnes-Jewish St. Peters

Patient Name_____ **Date of Birth**_____ **Today's Date**_____

Ht: _____ Wt: _____

Why are you seeing the doctor today? _____

Referring Physician(s) _____ Primary Care Physician _____

PAST SURGICAL HISTORY:

Surgeries/Hospitalizations:	Year	Complications:

Have you had problems with General Anesthesia? Please circle: YES or NO

If yes, please describe: _____

Past Medical History: Please list any current Medical Conditions/Issues (For Example: diabetic, HBP)

FAMILY HISTORY:

Family Member:	Alive	Deceased	Age	Health Status or Cause of Death:
Mother				
Father				
Sister				
Brother				

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____

Children? _____ If yes, How Many? _____

History of Substance Abuse: ____ If Yes, What? _____

Current Smoker? _____ If Yes, How much? ____ppd _____Yrs Quit Smoking? When? _____

Drink Alcohol? _____ If Yes, How much? _____

Reviewed by: _____ *Date:* _____

MEDICATIONS:

Medication:	Dose:	How Often:	Side Effects:

Drug Allergies/Reactions:

_____

Preferred Pharmacy/Phone Number:_____

Review of Systems

Please Circle All Current Symptoms/Issues

CONSTITUTION: Activity/Appetite Change, Chills, Sweating, Fatigue, Fever, Unexpected Wt Changes
Head/Ears/Neck/Throat: Congestion, Dental Problems, Drooling, Ear Pain/Discharge, Facial Swelling, Hearing Loss, Oral Sores, Nosebleeds, Postnasal Drip, Runny Nose, Sinus Pain/Pressure, Sneezing, Sore Throat, Ringing in the Ears, Trouble Swallowing, Voice Changes
Breast: Tenderness, Redness, Lumps or Discharge **SKIN:** Color change, Paleness, Rash, Wound
Eyes: Eye Discharge, Eye Itching, Eye Pain, or Redness, Trouble w/ Bright Lights, Visual Disturbances
RESPIRATORY: Breathing Interruptions (Apnea), Chest tightness, Choking, Cough, Shortness of Breath, Wheezing
Cardiovascular: Chest Pain, Leg Swelling, Heart Palpitations
GI: Abdominal Distention, Abdominal Pain, Anal Bleeding, Blood in Stool, Constipation, Diarrhea, Nausea, Rectal Pain, Vomiting
Endocrine: Cold/Heat Intolerance, Excessive Thirst, Excessive Hunger, Excessive Urination
General Urinary: Difficulty Urinating, Pain w/ Intercourse, Painful Urination, Bed Wetting, Flank Pain, Frequency, Genital Sores, Blood in Urine, Menstrual Problems, Pelvic Pain, Urgency, Urine Decreased, Vaginal Bleeding, Vaginal Discharge, Vaginal Pain
Musculoskeletal: Joint Pain/Swelling, Back Pain, Gait Problem, Muscle Aches, Neck Pain/Stiffness
Allergy/Immuno: Environmental Allergies, Food Allergies, Immunocompromised
Neuro: Dizziness, Facial Asymmetry, Headaches, Light-headedness, Numbness, Seizures, Fainting, Tremors, Speech Difficulty, Weakness **HEMATOLOGIC:** Lymph Node Abnormality, Bruises/Bleeds Easily
PSYCH: Agitation, Behavior Problems, Confusion, Decreased Concentration, Depressed, Hallucinations, Hyperactive, Nervous/Anxious, Self-Injury , Sleep Disturbance, Suicidal Ideas
******PLEASE CIRCLE ALL CURRENT SYMPTOMS/ISSUES YOU ARE EXPERIENCING TODAY******

*Reviewed by:*_____ *Date:*_____

BJC Medical Group

Name: _____

DOB: _____

Receipt of Notice of Privacy Practices

Initial _____ I acknowledge I have received or I have been provided the opportunity to receive a copy of BJC's Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by BJC Medical Group.

Patient Communication Preferences

Phone number for voice message(s): _____

Cell number for text message(s): _____

Email address: _____

HIPAA Disclosure Authorizations(s)

Initial _____ **I authorize BJC Medical Group to provide the following person(s) with my protected health information:**

Print Name: _____ Relationship to Patient/Phone number: _____

Print Name: _____ Relationship to Patient/Phone number: _____

or

Initial _____ **I do not authorize BJC Medical Group to:**

Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in BJC's Notice of Privacy Practices.

Prescription Authorization

Initial _____ I authorize BJC Medical Group to allow the following person(s) to pick up prescriptions on my behalf:

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any BJC Medical Group provider.

_____ _____ _____

Signature of Patient/Personal Representative | Relationship to Patient | Date