NAME: _____ BIRTHDATE: ____/____/_____

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME PHONE: _____ WORK/CELL: _____

OCCUPATION: _____ SOCIAL SECURITY: ____-____-_____

E-MAIL ADDRESS: _____

EMERGENCY CONTACT: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? (PLEASE CHECK THOSE THAT APPLY)

___ FRIEND / RELATIVE ___ PRIMARY DR / RN ___ SAW SIGN / WALK-IN

___ PHONEBOOK ___ GOOGLE / INTERNET ___ NEWSPAPER AD

___ INSURANCE WEBSITE

FAMILY MEDICAL HISTORY

MOTHER: _____

FATHER: _____

BROTHER: _____

SISTER: _____

FAMILY DOCTOR: _____

DR. ADDRESS: _____ DR. PHONE: _____

CITY, STATE, ZIP: _____ DR. FAX: _____

MEDICAL HISTORY: (PLEASE CHECK THOSE THAT APPLY)

___ DIABETES ___ HEART DISEASE ___ STOMACH ULCER ___ REFLUX

___ LUNG DISORDER ___ KIDNEY BLOOD ___ CLOTS ___ HIGH BLOOD PRESSURE

___ CHOLESTEROL ___ SMOKER: 1 2 3 (PACKS/DAY)

OTHERS: _____

MEDICAL ALLERGIES: _____

MEDICATIONS: _____

_____

_____

PRIOR SURGERIES: _____

_____

HEIGHT: _____ **WEIGHT:** _____

REASON FOR VISIT TODAY: _____

_____

_____

Patient name: **Age** **Date of birth:** **Sex: M F** **Height:** **Weight:**

Surgeon:	Planned procedure:	Date of procedure:
Family Doctor:	Last seen: Phone:	
Cardiologist:	Last seen: Phone:	PLU sticker
Pharmacy Name:	Phone:	

Please place a check if you now have, or have ever had, any of the following:

Respiratory (breathing problems)	**Yes**	**Cardiovascular (heart or circulatory problems)**	**Yes**	**Neurologic Problems (nerve problems)**	**Yes**
Recent cold, bronchitis, pneumonia		Fast or irregular heart beat		Stroke ☐ TIA (mini-stroke) ☐ Year:	
Sleep apnea ☐ Excessive snoring ☐		Previous heart surgery		Multiple sclerosis ☐ Polio ☐	
Use CPAP		Heart murmur		Weakness ☐ Paralysis ☐	
Asthma or wheezing		Heart valve problems ☐ Mitral valve prolapse ☐		Head injury Year:	
Shortness of breath at rest or on exertion		High blood pressure		Neuropathy Arms ☐ Legs ☐	
Emphysema/COPD		Heart attack Year:		Epilepsy/seizures	
Chronic bronchitis		High cholesterol		Migraine headaches	
Chronic cough or lung problem		Heart failure		Vertigo/Meniere's disease	
Tuberculosis Year:		Recent chest pain or tightness		Parkinson's Disease	
Sarcoid		Problems with arteries in neck		Dementia/Alzheimer's disease	
Hospitalized for breathing problems?		Problems with circulation to legs		RSD/complex regional pain syndrome	
Hematologic (blood problems)	**Yes**	Blood clots/DVT/pulmonary embolism		**Endocrine Problems**	**Yes**
Anemia (low blood count)		Do you sleep with 2 or more pillows?		Thyroid Overactive ☐ Underactive ☐	
Sickle cell anemia ☐ trait ☐		Can you walk up a flight of stairs without stopping?		Parathyroid disorder	
Easy bleeding or bruising		Can you do heavy work around the house?		Diabetes Insulin ☐ Pills only ☐	
Previous blood transfusion		Pacemaker ☐ defibrillator ☐		**Kidney Problems**	**Yes**
Are you on any blood thinners now?		Manufacturer:		Chronic kidney disease	
Psychological (mental health problems)	**Yes**	Cardiac cath Year:		Dialysis: hemo ☐ peritoneal ☐	
Anxiety ☐ Depression ☐		Stents When placed:		Kidney stones	
Panic disorders		**Gastrointestinal (digestive problems)**	**Yes**	Enlarged prostate	
Post-traumatic stress disorder (PTSD)		Hepatitis ☐ Cirrhosis ☐ Jaundice ☐		Incontinence	
Bipolar disorder		Chronic heartburn		Urinary tract infections	
Musculoskeletal	**Yes**	Ulcers		**Developmental Problems**	**Yes**
Chronic pain Neck ☐ Back ☐		Acid reflux/GERD		Developmental delay	
TMJ problems		IBS ☐ Ulcerative colitis ☐ Crohn's		Autism	
Scoliosis		Gastroparesis		ADHD	
Arthritis ☐ Gout ☐ Rheumatoid ☐		**Skin**	**Yes**	**Other Problems**	**Yes**
Previous spine surgery		Rashes		Cancer Where:	
Ears/Eyes	**Yes**	Open wounds Where?		Previous chemotherapy When:	
Poor hearing		Psoriasis		Previous radiation When:	
Deaf		MRSA		HIV/AIDS	
Hearing aids		Shingles within past 3 months		Recent infection or fever	
Poor vision		**Dental**	**Yes**	Herpes	
Blindness		Dentures: Full ☐ Upper ☐ Lower ☐			
Glaucoma		Partial ☐ Upper ☐ Lower ☐			
Contact lenses ☐ Glasses ☐		Veneers ☐ Caps/crowns ☐			
		Are any of your teeth loose?			

PLU sticker

NKDA

Drug Allergies/sensitivities	Reaction

	Yes	Reaction
Latex		
Contrast dye		
Iodine/shellfish		
Tape		
Eggs		

Women:

	Uncertain	Yes	No		Yes	No		Yes	No
Are you pregnant?				Are you breastfeeding			Are you menopausal?		
Are you recently pregnant?				Date of last menstrual period:			If yes, for how long?		

Surgical/Anesthesia History

Please list all previous surgeries or procedures requiring anesthesia:

Have you had any problems or complications with anesthesia, other than nausea or vomiting? Yes ☐ No ☐ If yes, explain:

Have any of your blood relatives had major problems or complications with anesthesia, such as malignant hyperthermia or pseudocholinesterase deficiency? Yes ☐ No ☐ If yes, explain:

Do you have problems with your neck or opening your mouth? Yes ☐ No ☐
Do you have concerns you want to discuss with the anesthesiologist? Yes ☐ No ☐

Pain Screening

Do you have chronic pain? Yes ☐ No ☐ If yes, where is your worst pain located?
Rate the severity of your pain: (0 = no pain, 10 = worst imaginable pain)
Do you take narcotic pain medications at least several times per week? Yes ☐ No ☐

Substance Screening

Do you smoke? Yes ☐ No ☐	Do you drink alcohol? Yes ☐ No ☐	Do you now, or have you ever, used recreational or IV drugs? Yes ☐ No ☐
If yes, how much per day:	If yes, how frequently?	If yes, which drugs and last used?
Total number of years smoked:	If yes, how much at a time?	
If you quit smoking, how long ago?	If recovering alcoholic, for how long?	

Bring a current list of medications, vitamins and herbal supplements to all appointments!

Interview with: _____ Date/time: _____

Interview by: _____ Date/time: _____

Lawrence Kassan DPM, LLC
3458 Cottman Ave
Phila, PA 19149
(215) 333-8637

HIPAA-ACKNOWLEDGEMENT OF RECIEPT

Notice of Privacy Practices

Printed Patient Name_____

Patient Date of Birth _____

We at the office of Dr. Lawrence Kassan are required by law to maintain privacy and provide Individuals with the attached Notice of our legal duties and privacy practices with respect to Protected health information. If you have any objections to the Notice, please ask to speak to our HIPAA Compliance Officer.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice Document.

_____ _____
Signature of Patient or representative Date

_____
Printed name of Patient or representative

_____
Relationship to patient

Permission To Obtain Medical Records

By signing below, I grant permission to The office of Lawrence Kassan,DPM to obtain medical records ,including previous doctor's records, hospital records, and other medical information that may contribute to my healthcare.

_____ _____
Signature of patient or representative Date

_____
Printed name of patient or representative

_____
Relationship to patient