NEW PATIENT WORKERS COMPENSATION INFORMATION

Patient (FULL, LEGAL) Name____

Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed

DOB: ___________________________________ Last Four Digits of SSN:______________

Patient's Address:____

Phone number: ____________________________

Employer Name:____

Preferred Language:_________________________

Have you ever been in this practice before? ☐Yes ☐No

Marital Status: ☐ Married ☐ Single ☐Widowed ☐ Other________________

Please Circle Race: ☐ Black/African American ☐ American Indian ☐Asian ☐ White ☐Hawaiian/Pacific Island ☐Other

Please circle Ethnicity: Hispanic/Latino Not Hispanic/Latino

Date of Injury/DOI:_________________________

Employer Name:___________________________

Signature: ____ Date:____________________

Name: ______________________________ **DOB:** ______________________________

Smoking Status: ☐ Former ☐ Never a smoker ☐ Current smoker, Packs per day__________

Weight____________________ **Height**____________________

Review of Systems: Do you have any of the problems related to the following symptoms? Check the appropriate box.

	Yes	No		Yes	No
Fatigue	☐	☐	**Swelling in hands/legs/feet**	☐	☐
Fever	☐	☐	**Abdominal Pain**	☐	☐
Sore throat	☐	☐	**Black or tarry stool**	☐	☐
Loss of hearing	☐	☐	**Bloody stool**	☐	☐
Shortness of breath	☐	☐	**Nausea/vomiting**	☐	☐
Cough	☐	☐	**Muscle weakness**	☐	☐
Chest pain	☐	☐	**Easy bruising**	☐	☐
Pain/cramps when walking	☐	☐	**Joint Pain, where________**	☐	☐
Feeling of feet being cold	☐	☐	**Dizziness**	☐	☐
Numbness in hands/legs/feet	☐	☐	**Temporary loss of vision in eye(s)**	☐	☐
Tingling in hands/legs/feet	☐	☐	**Fainting**	☐	☐
Skin Lesions/wounds	☐	☐	**Headache**	☐	☐

Family History: (please select all that apply)

	Father	Mother	Brother	Sister
Breast Cancer				
Ovarian Cancer				
Other Cancer				
Heart Disease				
Stroke				
Hypertension				
Diabetes				
Atherosclerotic Vascular Disease				
Aneurysm				
Other (please specify)				

For nurse, only: BP________ HR ________ Temp ________ RR _______ Sat ________ Ht ________ Wt ________

Allergies: ☐ None **Latex Allergy:** ☐ Yes ☐ No **DOB:** ___________________________

Medication Allergies Reaction:

____

Food Allergies: ☐ No ☐ Yes

Dye Allergies: ☐ No ☐ Yes

Shellfish/Iodine Allergies: ☐ No ☐ Yes

Current Medications: ☐ Check here if attaching a home medication list.

Preferred Pharmacy: Name__________________________ Phone Number: ________________________________

Is this a mail-in pharmacy? ☐ Yes ☐ No

Medication	Dosage	Times per day	Prescribing Doctor

Social History: Occupation: ________________________________ **DOB:** _____________________

Alcohol: ☐ No ☐ Yes Drinks per day/week: ____

Drug Use or Addiction: ☐ No ☐ Yes Drug(s): ____

Caffeine use: ☐ No ☐ Yes How often? _______________________

Past Medical History: ☐ No Medical History Check all that apply.

- ☐ Aortic Aneurysm
- ☐ Carotid Artery Stenosis
- ☐ Stroke
- ☐ Peripheral Arterial Disease
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Intermittent Claudication
- ☐ Atrial Fibrillation
- ☐ Murmur
- ☐ Heart Attack (MI)
- ☐ Venous insufficiency
- ☐ Colitis
- ☐ Constipation
- ☐ Diverticulosis/Diverticulitis
- ☐ Gallbladder disease
- ☐ Esophageal reflux
- ☐ Gastrointestinal Bleeding
- ☐ Hernia: _____________
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Intestinal obstruction
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Kidney Disease
- ☐ Colon polyps
- ☐ Hematuria
- ☐ Kidney stones
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Diabetes Mellitus
- ☐ Neuropathy
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ HIV
- ☐ Tuberculosis
- ☐ Alzheimer’s Disease
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson’s Disease
- ☐ Seizure Disorder
- ☐ Anemia
- ☐ Coagulation Defects
- ☐ Sickle Cell Disease
- ☐ DVT: ____________
- ☐ Pulmonary Embolism
- ☐ Lymphedema
- ☐ Cancer: __________
- ☐ Other: ___________

Past Surgical History: ☐ **No Surgical History** ***Please list surgeries and approximate dates.***

- ☐ AAA Repair
- ☐ Angiogram
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Graft/Fistula
- ☐ Brain Surgery
- ☐ Breast Biopsy
- ☐ Cataract Removal
- ☐ Cardiac Bypass
- ☐ Gallbladder Removal
- ☐ Heart Catheterization
- ☐ Heart valve replacement
- ☐ Hemorrhoid Surgery
- ☐ Hernia: __________
- ☐ Hysterectomy
- ☐ Transplant: __________
- ☐ Mastectomy [ ] L [ ] R
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ Prostate Surgery
- ☐ Thyroid Surgery
- ☐ Tonsils/Adenoids
- ☐ Splenectomy
- ☐ Back Surgery
- ☐ Neck Surgery
- ☐ Foot Surgery [ ] L [ ] R
- ☐ Total Hip [ ] L [ ] R
- ☐ Total Knee [ ] L [ ] R
- ☐ Tubal Ligation
- ☐ PD Catheter
- ☐ Amputation:__________
- ☐ Carotid Surgery
- ☐ Leg bypass
- ☐ Stab phlebectomy
- ☐ Ablation [ ] L [ ] R
- ☐ Colon surgery

Other: ____________________

Other: ____________________

Patient Signature: ____ **Date:** _______________________________

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A.
& SWFL VASCULAR CENTER

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: ____ DOB: ______________________

☐ I give my permission to **Surgical Specialists of Southwest Florida, P.A.**, to disclose my protected health information to the following family or friends:

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

OR

☐ I request that all my protected health information be disclosed only to "Me" and no one else other than my other healthcare providers.

May we leave a message on your answering machine/voice message about your medical care? ☐ Yes ☐ No

By signing this form, you are granting consent to Surgical Specialists of Southwest Florida to use and disclose your protected health information for purposes of treatment payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I understand that I am financially responsible for all charges of services to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for physicians' services to the physician furnishing the services.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 936-8555. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

We utilize an automated system to remind you of your next appointment. By signing this you also give us permission to include you in this automated calling system. If you do not wish to be reminded of future appointments, please let the receptionist know this.

Patient Signature: ______________________________________ **Date:** ____________________ **Patient**

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

Health Questionnaire (PHQ-9)

Date of visit: ______________

Patient Name: ____________________________ DOB: _________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not At all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or helpless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + ______ + ______ + _____

Add totals together ______

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult