Patient Intake

What is the reason for your visit? _____

_____

Which Pharmacy Do You Use? _____

Address or Nearest Cross Streets: _____

Have you Had a Flu Vaccine? No____ Yes____ If Yes, Date: _____

Have you had Colorectal Cancer Screening? ___ No ___ Yes if yes please tell us which type and the date _____

Smoking Status: ____ Non-smoker _____Smoker _____Packs a Day

How often do you Drink Alcohol? ____ Never ____ Rarely ____ Daily ____Weekends
____ 1-2 a Day ____ More than 2 a Day

Personal Medical History: Current Conditions (Check all that apply)

___ Abdominal Pain

___ Allergies (Seasonal)

___ Anemia

___ Anxiety

___ Arthritis

___ Asthma

___ Lower Back Pain

___ Bipolar Disorder

___ Blood Clots

___ Cancer

___ Cataracts

___ Chronic Fatigue

___ Coronary Artery Disease

___ Sleep Apnea

___ Heart Burn / Gastric Reflux

___ Hyperlipidemia

___ Hypertension

___ Hypothyroidism

___ Irregular Menses'

___ Joint Pain

___ Kidney Disease

___ Liver Disease

___ Nausea

___ Obesity

___ Osteoporosis

___ Shortness of Breath

___ Dementia

___ Depression

Continued....

___ Type 2 Diabetes ___ Type 1 Diabetes

___ Edema ___ Fibromyalgia

___ Urinary Incontinence ___ Gout

___ Varicose Veins ___ Headaches

___ Vomiting ___ Heart Disease

___ Peripheral Vascular Occlusive Disease (PVOD)

___ Chronic Obstructive Pulmonary Disease (COPD)

___ Polycystic Ovarian Syndrome (PCOS)

___ None

Surgical History, please select any you have had:

___ Appendectomy ___ Hysterectomy

___ Pacemaker/Defibrillator ___ Cataract Surgery

___ Knee Surgery ___ Gallbladder Removal

___ Heart Surgery ___ Nasal Surgery

___ Hip Surgery ___ Tonsillectomy

___ Sleeve Gastrectomy ___ Gastric Bypass

___ Lap band: Type _____ ___None

___ Other, please specify:

What Medical Problems Run in your Family?

List your Current Medications, Supplements or Vitamins you take Including Dose and Frequency Taken

Do you have any allergies to Medications? ___ No ___ Yes (Please List)

TUCSON BARIATRIC/WOUND CENTER OF TUCSON
CONSENT TO TREATMENT

I hereby give permission to Jeffrey Monash, MD FACS, Amanda Mulvihill, FNP-C, or Renee Lujan, NP to provide Medical Treatment. I allow the practice to file for Insurance Benefits to pay for the care I receive.

I understand that:

- The practice may have to send my medical record information to my insurance company

- I must pay my share of the costs

- I must pay for the cost of these services if my insurance company does not pay, or if I do not have insurance.

I understand that:

- I have the right to refuse any procedure or treatment

- I have the right to discuss all medical treatment with my provider

Printed Name: _____

Signature: _____**Date:** _____