

HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES / EXAMS? Please include the year and Physician (if known).						
PROCEDURE	DATE			PROCEDURE	DATE	
CATARACT SURGERY		Y	N	HERNIA REPAIR		Y N
TONSILLECTOMY		Y	N	HIP REPLACEMENT		Y N
APPENDECTOMY		Y	N	KNEE REPLACEMENT		Y N
GALLBLADDER (CHOLECYSTECTOMY)		Y	N	HEART SURGERY		Y N
HYSTERECTOMY		Y	N	BREAST EXAM		Y N
GYNECOLOGICAL EXAM		Y	N	MAMMOGRAM		Y N
RECTAL EXAM		Y	N	PROSTATE EXAM		Y N
PHYSICAL EXAM		Y	N	SIGMOIDOSCOPY / COLONOSCOPY		Y N
PLEASE DESCRIBE YOUR EXPERIENCES WITH THE FOLLOWING						
COFFEE		Y	N	EXERCISE PATTERNS		Y N
TOBACCO		Y	N	SEATBELT USE		Y N
ALCOHOL		Y	N	COUNSELING		Y N
SLEEP PATTERNS		Y	N	HAZARDOUS ACTIVITIES		Y N
FAMILY HISTORY						
RELATION			INFORMATION			
FATHER						
MOTHER						
BROTHERS / SISTERS						
SPOUSE						
CHILDREN						
DO YOU HAVE, OR IS THERE A FAMILY HISTORY OF THE FOLLOWING (please list type and relative)						
CONDITION	RELATIVE			CONDITION	RELATIVE	
CANCER		Y	N	STROKE		Y N
TUBERCULOSIS		Y	N	EPILEPSY		Y N
DIABETES		Y	N	MENTAL ILLNESS		Y N
HIGH BLOOD PRESSURE		Y	N	SUICIDE		Y N
HEART PROBLEMS		Y	N			
ADDITIONAL HISTORY						

Assignment of Benefits and Release of Medical Information

By signing below I authorize Joan Smith, D.O.; P.A. and her staff to submit medical claims to my insurance company commencing from the date indicated below. Additionally, I authorize payment of medical benefits directly to Joan Smith, D.O.; P.A. for those same services rendered.

By signing below I authorize the release of any medical information needed to process claims through my insurance company for services rendered while under Dr. Smith's care.
