AKKARY
Surgery Center

1100 Fort Pierpont Drive, Suite 101 Morgantown, WV 26508
Phone: 304-241-1100 www.yourdreambody.com Fax: 304-983-8800

Date: _____

NEW PATIENT HISTORY FORM

First Name: _____ Middle Initial: _____ Last Name: _____Age: _____ years

DOB: _____ **Gender: M / F** **Social Security Number:_____**

Address: _____

City/State: _____ Zip code: _____ Occupation: _____

Phone: (H) _____ (W)_____ (C) _____

E-mail: _____ Preferred Method of Contact _____

Primary Care Doctor: _____ Doctor location: _____

Phone number: (_____) _____ FAX: (_____) _____

Referring Physician: _____ Physician's location: _____

Phone number: (_____) _____ FAX: (_____) _____

Emergency Contact Name: _____ Phone number: (_____) _____

Insurance: _____ ID: _____ Group ID: _____

Pharmacy:_____ Phone:_____ FAX:_____

Chief Complaint: _____

History of Present Illness:

- **Onset**: When did the problem start? _____
- **Course:** Is the problem improving---stable---worsening?
- **Duration:** How long have you been suffering from this problem? _____
- Lowest Adult Weight: _____ When? _____
- Highest Adult Weight: _____ When? _____
- Female patients: Number of pregnancies: ____, Number of deliveries: ____, Number of abortions: ____

How did you hear about our office? Google Social Media Billboard Family/Friend Other:_____

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Name:_____ **Date of Birth:**_____

Review of Systems (please circle)

SYSTEM	SYMPTOM			
General	None.	Fever/Chills.	Hair Loss.	
Skin	None.	Rash.	Ulcers.	Skin Changes.
Psychiatric	None.	Mood Swings	Suicidal/homicidal ideation	Visual/auditory hallucinations.
Neurological	None.	Headaches Stroke	Numbness/tingling Memory problems.	Upper extremity weakness Speech problems.
Eyes	None.	Pain.	Discharge.	Vision Problems
Ear/Nose/Throat	None.	Dizziness	Swollen neck glands Dental Problems	Sore throat. Oral ulcers/sores
Cardiovascular	None.	Chest Pain. Heart Racing	Shortness of breath.	Leg Swelling
Respiratory	None.	Cough up blood Cough. Snoring	Wake up Gasping Asthma.	Excessive daytime drowsiness Night sweats.
Gastrointestinal	None.	Heartburn	Constipation/diarrhea Nausea/vomiting.	Blood per rectum Abdominal pain.
Genitourinary	None. Males: Female:	Discharge Scrotal pain Irregular menses.	Ulcers/sores Blood in urine Bladder/kidney infections Scrotal swelling Painful menses Pain with intercourse	Pain with urination Increased frequency of urination Kidney stones Too much/too little blood flow
Endocrine	None.	Excessive thirst.	Increased facial or body hair. Intolerant: hot/cold temperatures	Decrease in facial or body hair
Musculoskeletal	None.	Joint Pain	Limited joint motion	Joint Redness/swelling.
Lymphatic	None.	Swollen glands.	Leg swelling	

Please Initial: _____ I certify that I will discuss any problems I circled in the Review of systems above with my Primary Care Provider

Medical History: _____

_____

_____

_____

Surgical History: _____

_____

_____

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Name:_____ **Date of Birth:_____**

Medications:

Please list all medications <u>including</u> herbal supplements, vitamins, over the counter drugs, birth control.
If more space is needed, please add supplemental paper(s)

Medication	Dose	Frequency	Indication/Reason

Allergies:

Type	Allergen	Reaction
Medications		
Food		
Environmental		
Betadine/Iodine	**YES NO**	
Oral/IV contrast	**YES NO**	
Other (Please Specify)		

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Name:_____ **Date of Birth:_____**

Social History:

1- Tobacco use: Y / N If yes, specify type: _____ Amount per day: _____ How many years? _____

2- Do you drink alcohol? Y / N Do you have a history of alcoholism? Y / N Years sober: _____
If yes to either question, specify type _____ how much? _____ how often? _____

3- History of drug abuse? Y / N
If yes, specify type: _____ how much? _____ how often? _____

Family History: _____

Patient Name (print): _____

Patient Signature: _____ **Date**: _____

Provider Signature: _____