Mount Nittany Physician Group -- Reconstructive and Cosmetic Surgery

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Office Phone 814-231-7878
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MEDICAL HISTORY

Personal Information

Name____ Date of Birth__________________ Sex________

Address____

City ____State _____________ Zip Code _______________

Phone (home)____________________ (cell)______________________ (work)_______________________

E-Mail Address ____

Would you like to receive promotional information e-mailed to you at this address? You will not receive email from other organizations. _________ Yes _______ No

Social Security # _________________________________ Married___________ Single _____________

Occupation______________________________ Employer ______________________________________

Emergency Contact_____________________________________ Relationship______________________

Phone (primary number)___________________________ (other)_________________________________

Name of Primary Care Physician_________________________________ Phone____________________

Referring Physician (if different)_________________________________ Phone____________________

Please contact me with my health information (test results, etc.) as follows:

By telephone: ( ) Home Number___________________

( ) Work Number___________________

( ) Cell Number ___________________

May leave messages on my home answering machine: Yes_______ No_______

May leave messages on my work voice mail: Yes_________ No________

May leave messages with:____

May release medical information to the following:

____

Reason for Visit____

____

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Patient Name______________________________ Date of Birth_____________________

MEDICAL HISTORY – CONTINUED

Please check all that apply to you and explain:

( ) Arthritis ______________________
( ) Asthma ______________________
( ) Blood/bleeding disorder ______________
( ) Depression/anxiety ________________
( ) Diabetes ______________________
( ) Gastrointestinal problems ____________
( ) Gynecological problems _____________
( ) Heart disease ___________________
( ) Hepatitis ______________________
( ) High blood pressure ________________
( ) High cholesterol _________________
( ) HIV/AIDS _____________________
( ) Liver disease ____________________
( ) Lung problems ___________________
( ) Prostate problems _________________
( ) Stomach problems ________________
( ) Seizures/epilepsy _________________
( ) Skin disorder ____________________
( ) Shingles ________________________
( ) Stroke _________________________
( ) Thyroid problems _________________
( ) Tuberculosis _____________________
( ) Ulcers __________________________
( ) Kidney/bladder problems ____________

Surgical History

Type of Surgery	Date	Type of Surgery	Date

Allergies

Reactions

( ) Penicillin ______________________
( ) Sulfa ______________________
( ) Morphine ______________________
( ) Latex ______________________

Reactions

( ) CT Dye______________________
( ) Aspirin ______________________
( ) Tape ______________________

Other Allergies	Reactions

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Patient Name______________________________ Date of Birth____________________

MEDICAL HISTORY – CONTINUED

Current Medications

Please list any medications you are currently taking, including prescription medications, over-the-counter medications (for example, aspirin, vitamins), herbal medicine or alternate therapy

Name of medication	Dose	How often do you take it?	When did you start taking it?

When was your last tetanus shot?____

When was your last flu shot? ____

Do you use (or did you use):

( ) Yes ( ) No Tobacco Packs per day __________________________
( ) Yes ( ) No Alcohol How often ____________________________
( ) Yes ( ) No Illegal Drugs Type/Amount___________________________

Height ___________________ Weight ____________________

Patient Name________________________________ Date of Birth______________________

MEDICAL HISTORY – CONTINUED

Family History

Have any of your relatives had a chronic illness (for example, cancer, heart disease, diabetes)?

Relative	Specify Chronic Illness(es)	Living	Deceased
Biological Mother	____________________	( )	( )
Biological Father	____________________	( )	( )
Maternal Grandmother	____________________	( )	( )
Maternal Grandfather	____________________	( )	( )
Paternal Grandmother	____________________	( )	( )
Paternal Grandfather	____________________	( )	( )
Siblings	____________________	( )	( )
Aunt(s)	____________________	( )	( )
Uncle(s)	____________________	( )	( )

INSURANCE AUTHORIZATION

"I authorize **Emily A. Peterson, MD** to furnish information to the insurance carrier concerning my illness and treatments and I assign to the physician all payments for medical services rendered to me. I understand that I am responsible for any amount not covered by my insurance."

Patient Signature:_______________________________________
Date_________________________