

HEART AND LUNG SURGERY SPECIALISTS, P.A.

JEFFERY S. SNYDER, M.D., F.A.C.S.

Richard Proia , M. D.

Date: _____

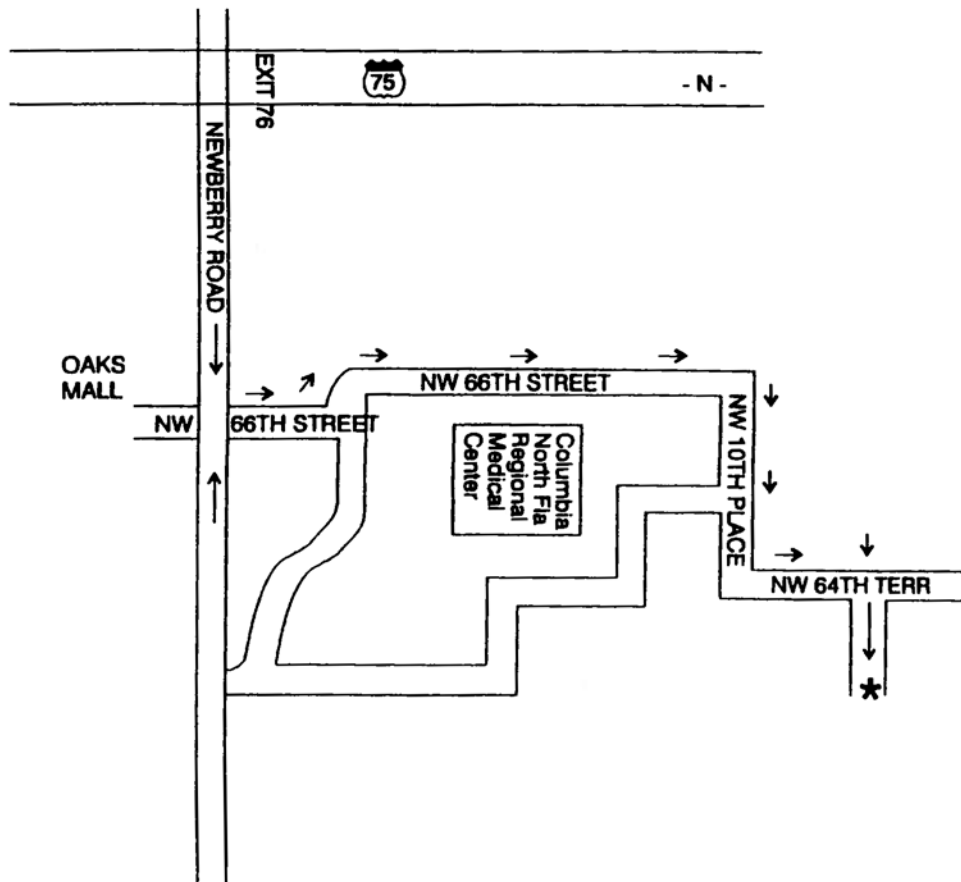
Time: _____

Dear Patient:

We would like to welcome you to the Heart and Lung Surgery Specialists, P.A.

Please complete the enclosed **History and Registration Form** and bring this form, a list of your medications and your insurance cards to your appointment time and date shown above.

Thank you.



**North Florida Surgical Associates
1121 NW 64th Terrace Ste. B
Gainesville Fl, 32605
352-331-3583**

**Jeffery S. Snyder M.D
Richard R. Proia M.D.**

Date: / /

Name _____ **Age** _____ **Birthdate** _____ **Gender** _____
Social Security _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone Numbers
Home () **Work** () **Cell** ()

Who Referred you here?

Who is your primary doctor?

What is the reason you are here? **Heart?** **Lung?** **Other?**

What (if any) are your symptoms? Chest pain ? ___ **SOB** ___
None? ___ **Other** _____

When do you have these symptoms? With exercise ___ **at rest** ___
All the time ___ **no symptoms** _____

List any medical problems you have or had.

a. _____

b. _____

c. _____

d. _____

Height _____ **Weight** _____

Married _____ Single _____ Divorced _____

Widowed _____ Separated _____

Do you smoke ? _____ How many packs a day _____ How many years.

Have you stopped smoking? _____ When _____

Never smoked _____ Do you drink alcoholic drinks ? _____ How many per day _____

Week _____ Occasionally _____

How much exercise do you get per day ? _____

Walking Running treadmill swimming ect.

Minutes per day _____ or week _____ or are you sedentary and rarely exercise _____

How far can you walk on flat ground if you try hard? _____

What cause you to have to stop ? _____

Angina _____ Leg pain _____ SOB _____ Fatigue _____

List any surgeries you have had and the approximate year you had it.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List ALL medications or over the counter drugs you take AND doses and how many per day.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

List any drug allergies you have and what reaction does it cause.

Do you have any of the following or have had any of these.

| Constitutional | Weight loss | Weight gain | How much? | |
|----------------|-----------------|---------------------|---------------------|---------|
| Eyes | Cataracts | Glaucoma | Loss of vision | Glasses |
| ENT | Hearing Aids | | Poor hearing | |
| Mouth | Oral sores | Bad Teeth | Mouth infection | |
| Heart | Angina pain | Heart attack | Heart failure | |
| | Rheumatic fever | Valve problems | High Blood Pressure | |
| | Palpitations | Atrial fibrillation | | |
| Chest | Pneumonias | Cough | Coughing up blood | |
| | Emphysema | COPD | SOB? At rest | |

With exercise Asthma Lung surgery
Lung Cancer Wheezing
 Cancer **Any history of cancer?** **What body area**
How was it treated? **Surgery?** **Radiation?**
Chemotherapy
 GI System **Ulcers GI Bleeding Other**
 Legs **Leg cramps with exercise?** **Leg cramps at night?**
Leg cramps go away when you stop exercising?_____
Any varicose veins? _____ Small spider veins _____ Big bulging veins _____
Any vein stripping operations? _____ Any history of blood clots in
legs? _____ Any history of phlebitis ? _____ Do you have poor circulation ? _____
 GU **Any urinary tract problems? _____ Prostate trouble? _____ Infection _____**
Blood in urine _____ Is it hard to start your urine? _____
 Skin **Any rashes _____ Infection _____ Open sores _____ Cancer _____**
 Neurological **Stroke Mini strokes Blindness Memory loss Blackout**
Confusion Seizures Paralysis Difficulty standing or walking
Difficulty with speech
 Endocrine **Diabetes Use Insulin Pills or diet Thyroid problems**
 Hematologic **Immune system Easy bruising Abnormal bleeding with cuts or**
Surgery _____
Poor healing Poor resistance to infection Immune system weakness
Leukemia Lymphoma
 Family history **Heart disease Strokes Bleeding problems**
 Personal **Employed _____ What type of work _____ Retired _____**

Patient Registration Form

(Please Print)

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status Married Single Divorced Widowed Legally Separated Other

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening
Cellular _____ Pager _____ May we contact you at work? Yes No

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ **Date** _____