GARDEN CITY COLON & RECTAL SURGICAL PRACTICE, P.C.

Victor A. Gallo, M.D. Michael V. Gallo, M.D.

LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS CITY STATE ZIP

TELEPHONE NUMBER S.S. NUMBER

AGE SEX DOB

OCCUPATION EMPLOYER

BUSINESS ADDRESS TELEPHONE NUMBER

MARITAL STATUS SPOUSE'S NAME DOB

PRIMARY CARE PHYSICIAN'S NAME & ADDRESS TELEPHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

COMPANY NAME TELEPHONE NUMBER

ADDRESS NAME OF POLICY HOLDER DOB SEX

ID# GROUP NO. RELATIONSHIP TO POLICY HOLDER

SECONDARY INSURANCE INFORMATION

COMPANY NAME TELEPHONE NUMBER

ADDRESS NAME OF POLICY HOLDER DOB SEX

ID# GROUP NO. RELATIONSHIP TO POLICY HOLDEER

Do we have your permission to leave a message on your answering machine. _____yes or _____no

I request that payment of authorized Medical Benefits be made on my behalf to Drs. Gallo for bills for services furnished to me by the above providers. I authorize any holder of medical information about me to be released to my insurance company and its agents to determine those benefits payable for related services. I will be responsible for any deductibles, co-insurances or balances not paid for me by my insurance company or companies.

Patient's Signature________________________________ Date______________________

Victor A. Gallo, M.D Michael V. Gallo, M.D.

NAME____ DATE_________________________

PATIENT HISTORY

Referring Doctor/Person________________________ Family Medical Doctor_________________

List all your other Doctors/Specialists____

What is the reason or condition that brings you to our office?

List all of your medical conditions (i.e. diabetes, heart attack, hypertension, stroke, etc.).

List all prior surgeries (include date, facility and surgeon).

Hospitalizations other than for surgery:

Do you take any prescription medications? YES or NO

If yes, please list your current medications and dosages.

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

Please list the non-prescription medications which you take.

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

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NAME________________________ DATE______________

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES? NO or YES
(If yes, please list name of medicine and type of reaction):

____
____
____
____
____

HABITS

Tobacco_______________________________________
Alcohol_______________________________________
Drugs____
Diet____

Obstetrical History (women only): Date of last menstrual cycle ____________

How many times were you pregnant? ____________
How many vaginal deliveries? ____________
How many Caesarian sections? ____________
Is there a chance that you could currently be pregnant? _____

FAMILY HISTORY

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other(specify)		

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NAME________________________ DATE______________

REVIEW OF SYSTEMS

CONSTITUTIONAL SYSTEMS
Appetite Change	Y N
Chills	Y N
Fever	Y N
Headache	Y N
Weight Loss	Y N

CARDIOVASCULAR
Angina	Y N
Arrhythmia	Y N
Endocarditis	Y N
Heart Attack	Y N
Heart Valve Replacement	Y N
High Blood Pressure	Y N
Mitral Valve Prolapse	Y N

RESPIRATORY
Asthma	Y N
Chronic Cough	Y N
Emphysema/Bronchitis	Y N
Shortness of Breath	Y N
Tuberculosis	Y N

SKIN
Persistent Itching	Y N
Unexplained Perspiration	Y N
Rash	Y N

NEUROLOGICAL
Dizziness	Y N
Numbness	Y N

GASTROINTESTINAL
Heartburn	Y N
Nausea	Y N
Vomiting	Y N

ENDOCRINE
Diabetes	Y N
Pituitary Disease	Y N
Thyroid Disease	Y N

MUSCULOSKELETAL
Arthritis	Y N
Joint Pain	Y N

PHARMACEUTICAL
Anti-Inflammatories	Y N
Aspirin Products	Y N
Coumadin	Y N
Glucophage	Y N
Nitrates	Y N
Persantine	Y N
Plavix	Y N

HEMATOLOGICAL
Bleeding Problem	Y N
Blood Transfusions	Y N
Hepatitis	Y N
HIV (AIDS)	Y N
IV Drug Use	Y N
Swollen Glands	Y N

Steroids? Y N

Antibiotic prophylaxis prior to medical/dental procedures? Y N