# NORTH SHORE SURGICAL SPECIALISTS, M.D., P.C.

**310 East Shore Road, Suite #203 Great Neck, NY 11023**
**Tel: (516) 482-8657 / Fax (516) 829-0002**

__ **Dominic A. Filardi, M.D., F.A.C.S.**
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__ **Paul Katz, M.D., F.A.C.S.**
__ **Lewis Kurtz, M.D., F.A.C.S.**
__ **Angelo J. Procaccino, M.D., F.A.C.S.**
__ **Howard Nadjari, M.D., F.A.C.S.**
__ **Robert J. Dring, M.D.**

Patient name: ______________________ Date: ______________________
Date of Birth: ______________________ Age: ______________________
Reason for Visit/Nature of Complaint: ______________________
Referring Physician name, Address, Phone ______________________

**Do you have an implantable Device ? Yes / No If Yes, is it an AICD ____ Pacemaker ____ Other____**

DO YOU OR HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING CONDITIONS:

| Condition | Yes | No | If Yes Please Explain |
|---|---|---|---|
| Recent Weight Loss, Loss of Appetite | | | |
| Eye Problems | | | |
| Ear, Nose or Throat Problems | | | |
| Heart or Vascular Problems | | | |
| A. Heart Attack/Congestive Failure | | | |
| B. Heart Murmur, Mitral Valve Prolapse | | | |
| C. Phlebitis/ Blood Clots/ Vascular Disease | | | |
| D. Irregular Heart Beat | | | |
| E. High Blood Pressure | | | |
| Breathing Problems | | | |
| A. Shortness of Breath | | | |
| B. Asthma | | | |
| C. Pneumonia/Tuberculosis | | | |
| D. Emphysema or Chronic Bronchitis | | | |
| Stomach or Intestinal Problems | | | |
| A. Liver Disease/Jaundice/Hepatitis | | | |
| B. Ulcers/Hiatal Hernia | | | |
| C. Bowel Disease/Colitis, Diverticulitis | | | |
| D. Diarrhea | | | |
| E. Bloody Stools | | | |
| F. Nausea/Vomiting | | | |
| Kidney, Bladder, Genital Problems | | | |
| A. Prostate Disease/Enlarged Prostate | | | |
| B. Kidney Disease/Kidney or Bladder | | | |
| Infection | | | |
| Problems with Muscles or Joints | | | |
| Problems with Skin or Skin Cancer | | | |
| Breast Problems | | | |
| A. Cancer | | | |
| B. Lumps | | | |

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| Condition | Yes | No | If Yes Please Explain |
|---|---|---|---|
| C. Discharge | | | |
| D. Pain | | | |
| Problems with Brain or Spinal Cord | | | |
| A. Stroke/Seizures | | | |
| B. Fainting/Migraines | | | |
| Psychiatric Problems | | | |
| Hormones | | | |
| A. Diabetes | | | |
| B. Thyroid Disease | | | |
| Bleeding Problems | | | |
| A. Bleeding Tendencies | | | |
| B. Transfusion Reactions | | | |
| History of Hernias | | | |
| History of Cancer(s) | | | |
| History of Alcoholism | | | |
| History of Drug Abuse | | | |

**PLEASE COMPLETE THE FOLLOWING ADDITIONAL INFORMATION:**

**LIST ALL OPERATIONS YOU HAVE HAD IN YOUR LIFETIME. PLEASE INCLUDE THE TYPE OF PROCEDURE AND THE APPROXIMATE DATE.** ______________________________

______________________________________________________________
______________________________________________________________
______________________________________________________________

**HAVE YOU OR A BLOOD RELATIVE EVER HAD ANY PROBLEMS WITH ANESTHESIA.**
**YES ____ NO ____ IF YES, PLEASE EXPLAIN:** ______________________________

______________________________________________________________
______________________________________________________________

**PLEASE LIST ALL MEDICATIONS INCLUDING STRENGTH AND DOSAGES YOU TAKE ON A REGULAR BASIS: (Include over-the-counter and herbal/nutritional supplements)**

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**DO YOU HAVE ANY KNOWN ALLERGIES TO DRUGS OR MEDICATIONS? YES ____**

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**NO ______ IF YES, PLEASE LIST: ____________________**

**DO YOU HAVE ANY REACTION TO LATEX? YES ___ NO ____ IF YES, PLEASE EXPLAIN:**

**DO YOU HAVE ANY OTHER KNOWN ALLERGIES? YES ____ NO ____ IF YES, PLEASE EXPLAIN:**

**DO YOU SMOKE? YES ____ NO ____**
**HAVE YOU EVER SMOKED? YES ____ NO ___**
**IF YES BUT YOU STOPPED, WHEN DID YOU QUIT? ____________**
**IF YES: HOW MANY PACKS PER DAY? ___________**
**HOW LONG HAVE YOU OR DID YOU SMOKE? _________**
**DO YOU DRINK ALCOHOL? YES ____ NO ___ IF YES, HOW MUCH PER DAY? ____________________**
**HAVE YOU TAKEN ANY STEROIDS OR CORTISONES IN THE LAST SIX MONTHS? YES____ NO ____**
**IF YES, WHAT TYPE AND WHEN:**

FOR WOMEN ONLY

**PLEASE INDICATE YOUR LAST MENSTRUAL PERIOD: __________________**
**AGE AT 1st MENSES: ______________________**
**ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS: YES ____ NO ____**
**HAVE YOU EVER TAKEN BIRTH CONTROL PILL: YES_____NO______**
**IF YES, WHEN ____________________**
**FOR HOW LONG DID YOU TAKE THEM ____________________**
**HAVE YOU HAD ANY PREGNANCIES? ____________________**
**NUMBER OF PREGNANCIES? ____________________**
**NUMBER OF LIVE BIRTHS? ____________________**
**YOUR AGE WITH FIRST LIVE BIRTH? ____________________**
**DID YOU BREAST FEED? YES ____ NO ____**
**NUMBER OF CHILDREN BREAST FED?**
**HOW LONG DID YOU BREAST FEED?**
**HAVE YOU EVER TAKEN HORMONE REPLACEMENT THERAPY? YES ____ NO ____**
**HOW LONG? ____________________**
**AT WHAT AGE DID YOU GO THROUGH MENOPAUSE? ____________________**
**DATE OF LAST PAP SMEAR ________________ RESULTS __________________**

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**LIST ANY ILLNESS THAT RUNS IN YOUR FAMILY:** ______________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**LIST ALL ADMISSIONS TO THE HOSPITAL FOR ANY REASON, PLEASE INDICATE DATE:**

______________________________________________________________________

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______________________________ ______________________________
**Patient or Guardian Signature** **Date**

______________________________
**Reviewed By**