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

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__ Angelo J. Procaccino, M.D., F.A.C.S.
__ Howard Nadjari, M.D., F.A.C.S.

Patient name: ______________________ Date: ______________________

Date of Birth: ________________ Age: ______________________

Reason for Visit/Nature of Complaint: ______________________

Is this visit the result of a job or work related injury? Yes / No

Referring Physician name, Address, Phone ______________________

____

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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Date:

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. ____________________

____

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____

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 ______
NO ______ IF YES, PLEASE LIST: ____________________

____

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Date:

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: 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 ____
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 ______________

LIST ANY ILLNESS THAT RUN IN YOUR FAMILY: ______________

____

____

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

____

____

____

Patient or Guardian Signature

______________________ ______________________

Reviewed By **Date**