Louis Aviles MD PL

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Date: ____/____/_____ **Patient:** _____ _____ _____
(Last Name) (First Name) (MI)

Local Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Permanent Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Local Telephone #: (_____) _____-_____ **Permanent Telephone#:** (_____) _____-_____

Work Phone # :(_____) _____-_____ **Cellular Phone # :**(____) ____-_____ **E-mail:**_____

Female☐ Male☐ Married☐ Single☐ Widowed☐ Divorced☐ Retired☐ Student☐

Patient's Age_____ **Date of Birth** ____/____/_____ **SS#:** _____-____-_____

Spouse's Name: _____ **Spouse's Date of Birth**____/____/____ **SS#:** _____-____-_____

Emergency Contact: _____ **Relationship:** _____

Address: _____ **Phone #:** (_____) _____

Employer: _____ **Patient's Occupation:** _____

Employer's Address: _____ **Phone #:** (_____) _____

Responsible Party's Employer: _____ **Phone#:** (_____) _____

Name of Pharmacy you use?_____**Address:**_____

Have you or any member of your family ever been treated by Dr. Aviles? No___ Yes___ Who? _____

Referring Doctor: _____ **Primary Care Doctor**_____

PRIMARY INSURANCE

Insurance Company Name: _____

Insurance Company Address: _____
(Street)

_____ _____ _____
(City) (State) (Zip Code)

Insurance Co. Telephone #: (____) _____

Policy Holder's Name: _____

Policy #: _____ Group #: _____

Relationship to Policy Holder: ☐Spouse ☐Child ☐ Other_____

SECONDARY INSURANCE

Insurance Company Name: _____

Insurance Company Address: _____
(Street)

_____ _____ _____
(City) (State) (Zip Code)

Insurance Co. Telephone #: (____) _____

Policy Holder's Name: _____

Policy #: _____ Group #: _____

Relationship to Policy Holder: ☐Spouse ☐Child ☐ Other_____

Why are you here to see Dr. Aviles? _____

PAST MEDICAL HISTORY: Do you now or have you ever had any of the following? Check all that apply

___ Abnormal GI X-ray
___ Barrett's esophagus
___ "Colitis"
___ Colon polyps
___ Colon cancer
___ Diverticulosis/Diverticulitis
___ GERD /Esophagitis
___ Esophageal Stricture
___ Hiatal hernia
___ Bowel obstruction
___ IBD-Crohn's
___ IBD-Ulcerative colitis
___ Hemorrhoids

___ IBS-Irritable bowel syndrome
___ Abnormal liver enzymes
___ Hepatitis
___ Liver disease/ cirrhosis
___ Hemochromatosis
___ Fatty liver
___ Gallstones
___ Pancreatitis
___ Peptic ulcer disease (what type?)
__ Gastric ulcer __ Duodenal ulcer
___ Gastritis
___ Helicobacter pylori (if so, treated? Y N)

___ Childhood illnesses (circle which ones):
chickenpox, German measles, mumps
measles, whooping cough
___ Diphtheria
___ Influenza/ Flu
___ Polio
___ Rheumatic Fever
___ Scarlet Fever
___ AIDS/ HIV infection
___ Sexually transmitted dz. (Type?)
__ Chlamydia __ Gonorrhea
__ HPV __ Herpes __ Syphilis
___ Tuberculosis ___ Positive PPD skin test

Do you have or ever had any of the following medical conditions?

□Arthritis (osteoarthritis/ rheumatoid)
□Anemia
□GI Bleeding
□Hypothyroidism
□Osteoporosis/ Osteopenia
□Hypertension
□Stroke/TIA
□Cancer-what type? _____

□Lung disease
___Asthma
___Bronchitis
___COPD/emphysema
___SLEEP APNEA

□Heart disease
___Angina/ chest pain
___Arrhythmias
___CHF
___Heart attack
___Coronary stents
___AICD/ pacemaker
___Valvular heart dz.

□Diabetes?
___ insulin requiring (type 1)
___ adult onset (type 2)
___ insulin pump
___ steroid induced
□Kidney problems
□High cholesterol/triglyceride

Other Medical Problems (not listed above):

Medical problem:	Date diagnosed:	Medical problem:	Date diagnosed:

Past Surgical History:

GI:
___ Appendectomy
___ Bowel/ colon resection
___ Lysis of adhesions
___ Cholecystectomy (gallbladder removal)
□ Open □ Laparoscopic
___ Exploratory surgery
___ Gastric bypass/ LAP-BAND
___ Hiatal hernia repair
___ Inguinal hernia
___ Incisional hernia
___ Ventral wall hernia
___ Whipple
___ Ulcer surgery
___ Gastrostomy/ Jejunostomy tube

ENDOSCOPIC PROCEDURES:
___ EGD (upper endoscopy)
___ Colonoscopy
___ Sigmoidoscopy
___ ERCP
___ EUS (Endoscopic Ultrasound)

GYN:
___ Total hysterectomy (ovaries removed)
___ Partial hysterectomy (ovaries remain)
___ Ovaries removed
___ Ovarian cyst removal
___ Endometriosis
___ Laparoscopy
___ Cesarean section
___ Episiotomy
___ Gynecologic cancer surgery
___ Radiation therapy (pelvic area)
___ Mastectomy-right or left
___ Lumpectomy
___ Rectocele / Cystocele

OTHER:
___ Tonsillectomy
___ Thyroid surgery
___ Eye surgery
□ Cataract □ Lasik
___ Recent orthopedic surgery? (within 12 months)
□Shoulder □Hip □Knee □Ankle □Foot □Wrist

GU:
___ TURP
___ Prostatectomy
___ Radiation
□seeds □external radiation
___ Bladder surgery
___ Ileal conduit

CARDIAC:
___ CABG (bypass)
___ Coronary stents
___ Heart valve replacement
Which valve? _____
___ AICD
___ Pacemaker
___ Nodal ablation
___ Vascular surgery
___ Abdominal aorta repair (□ Stent)

Other surgical procedures not already listed:

Date	Type of Surgery	Hospital/ State	Date	Type of Surgery	Hospital/State

ALLERGIES: ○Ampicillin /penicillin ○Codeine ○Demerol ○Morphine ○Sulfa drugs ○Iodine ○Latex ○Contrast dye/ IVP dye ○Eggs ○Food allergies _____ ○Other_____

MEDICATIONS:

___ Aspirin (81, 160, 325, 500 mg) ___ Herbal medications:
___ Ibuprofen or similar type drug (Motrin, Aleve, Naprosyn, Anaprox, etc.)
___ Celebrex, Vioxx, Mobic (circle one) ___ Vitamins (circle): A, B, C, E Others:_____

Name	Dose	Frequency	Name	Dose	Frequency

VITALS (NURSE TO FILL OUT)	HT.	WT.	BP ___ / ___	HR	RR	Temp:

FAMILY HISTORY:

	Age	Health Status (if alive)	Age at Death	Cause of Death	Check all diseases that have occurred in your *IMMEDIATE* family (Grandparents, Parents or Children)
Father					□Cancer (circle): COLON, ESOPHAGEAL, GASTRIC
Mother					□Breast Ca □Prostate Ca □Ovarian □Cervical □Uterine
□Brother □Sister					□Colon Polyps □Crohn's □Ulcerative Colitis
□Brother □Sister					□Celiac Disease/ Sprue □Peptic Ulcer Disease
□Brother □Sister					□Irritable Bowel Syndrome
□Brother □Sister					□Liver disease (circle)-hepatitis, Hemochromatosis
□Brother □Sister					□Cirrhosis □Liver cancer □Gallstones □Alcoholism
□Son □Daughter					□Pancreatitis □Pancreatic Cancer
□Son □Daughter					□Anemia □Platelet disorder □Clotting problems
□Son □Daughter					□Heart trouble (Heart attack, CHF, arrhythmia)
□Son □Daughter					□Diabetes □Other:

SOCIAL HISTORY:

Marital Status (check one): ☐ Single ☐Married ☐ Widowed ☐ Divorced ☐ Have a Partner/ Significant Other
Place of Birth: _____ Recent Travel? _____
Current Occupation: _____ Former Occupation:_____
Do you smoke…□CIGARETTES? ____ packs per day ____ years smoking? …□CIGARS? □PIPE?
□Former smoker? When did you quit? _____ How much did you smoke? _____
Alcohol Consumption: □Beer □Wine □Liquor How much per day? ____ How much a week? ____
Caffeinated drinks: ☐ SODA ☐COFFEE ☐TEA ☐DECAF How many a day? _____
Regular Exercise? □No □Yes WHAT TYPE? _____

Name: _____ Date:

REVIEW OF SYSTEMS:

Have you recently (last 6 months) or **ever** had any of the following? *Check all that apply*

GENERAL:
____ Fatigue
____ Fevers
____ Decreased appetite
____ Weight loss
____ Weight gain

DERMATOLOGY:
____ Itching?
____ Rashes?
____ Skin cancer
____ Tattoos / Body piercing

HEAD & EYES:
____ Headaches/ Migraines
____ Loss of vision
____ Pink eye
____ Eye Pain/ Discharge (iritis)
____ Spots before eyes
____ Glaucoma
____ Eye Glasses
____ Cataracts
____ Macular Degeneration

EARS:
____ Hearing loss
____ Ringing in Ears

NOSE/ SINUSES:
____ Infection/ Sinusitis
____ Nose Bleeds
____ Postnasal drip

THROAT/ MOUTH:
____ Dentures
____ Bleeding gums
____ Hoarseness
____ Sore throat
____ Oral / mouth ulcers

PULMONARY:
____ Asthma
____ Bronchitis
____ Chronic Cough
____ Coughing Blood
____ COPD/ Emphysema
____ Pneumonia
____ Shortness of Breath
____ Wheezing
____ SLEEP APNEA
____ SNORING

ENDOCRINE:
____ Diabetes
____ Elevated Cholesterol
____ Elevated Triglycerides
____ Low Thyroid (Hypothyroidism)
____ High Thyroid
____ Goiter

CARDIOVASCULAR:
____ Abnormal EKG
____ Angina
____ Arrhythmia
____ Chest pain or discomfort
____ Congestive Heart Failure
____ Heart Attack
____ Heart Murmur
____ Heart Valve Disease or Endocarditis
*-do you require antibiotics pre-op*_____
____ High Blood Pressure
____ Low Blood Pressure
____ Palpitations
____ Swelling of ankles

GASTROINTESTINAL:
____ Abdominal pain
____ Anorexia (decreased appetite)___
____ Black / Bloody Stools
____ Change in bowel habits
____ Change in stool appearance
____ Constipation
____ Diarrhea
____ Difficulty Swallowing
____ Food stuck in esophagus
____ Heartburn / GERD
____ Hiatal Hernia
____ Gallbladder problems / Gallstones
____ Belching / Burping / Excessive Gas
____ Nausea
____ Parasites
____ Vomiting
____ Vomiting Blood
____ Rectal Pain
____ Stool incontinence

LIVER DISEASE:
____ Alcoholic Liver Disease
____ Cirrhosis
____ Elevated Liver Enzymes
____ Fatty Liver
____ Hepatitis
____ Jaundice (Yellow skin)
____ Liver Transplant
____ Liver mass

RENAL:
____ Bladder infection
____ Bladder Cancer
____ Blood in the urine
____ Kidney infection (pyelonephritis)
____ Kidney stones
____ Pain with urination
____ Urinary dribbling
____ Urinary frequency
____ Urinary urgency
____ Urinating after bedtime

MEN GENITOURINARY:
____ Enlarged Prostate
____ Elevated PSA
____ Prostate Cancer
____ Radiation therapy for Prostate cancer?

FEMALE GENITOURINARY:
Last period _____
pregnancies _____
____ Ectopic pregnancy
____ Heavy periods
____ Endometriosis
____ Painful intercourse

NEUROLOGY:
____ Speech Problems
____ Seizure
____ Confusion
____ Balance Problem
____ Numbness
____ Paralysis____
____ Weakness of one side
____ TIA (mini-stroke)
____ Stroke
____ Dizziness/ Fainting Spell/ Syncope

MUSCULOSKELETAL:
____ Arthritis
____ Back pain
____ Joint Pain
____ Fibromyalgia
____ Tender, swollen, red or hot joints
____ Gout
____ Lupus
____ Raynaud's
____ Scleroderma
____ Sjogren's

HEMATOLOGY:
____ Anemia
____ Blood Transfusion
When? ____ # units_____
Why? _____
____ Bleeding/ clotting disorder
____ Bleeding-excessive
____ Bruising easy?
____ Platelet problems

ONCOLOGY:
____ Personal history of Cancer?
What type? _____
____ Enlarged Lymph Nodes
____ Unexplained Weight Loss?
How Much? _____
How Long? _____

PSYCHIATRIC:
____ Anxiety
____ Bipolar
____ Crying Spells
____ Depression
____ Nervous Breakdown
____ Panic Attacks
____ History of Sexual Assault
____ Trouble Sleeping?/ Insomnia

ANYTHING ELSE NOT COVERED ABOVE?