Medication Summary Form

David A. Sherris M.D.
1237 Delaware Avenue
Buffalo, New York 14209

Patient Name : _____

Date of Birth : _____

Date : _____

Please list all current prescription and over the counter medications, vitamins or supplements you are taking daily:

Medication :	Dosage :

Please list ALL known drug allergies below:

_____

_____

_____

_____

_____

David A Sherris, MD

Health History Questionnaire- Review of Systems

Date _____ Name _____ DOB _____

List any current or recent health issues _____

Please respond yes or no to the following. The doctor will ask you for details

General Well-being

Yes No

___ ___ Fever
___ ___ Weight loss > 10 lbs
___ ___ Excessive Fatigue
___ ___ Recurrent Nausea Vomit
___ ___ Night Sweats

Eyes

Yes No

___ ___ Blurred Vision
___ ___ Trouble Focusing
___ ___ Recent Change in Vision

Cardiovascular

Yes No

___ ___ Chest Pain
___ ___ Heart Disease
___ ___ Heart Attack
___ ___ High Blood Pressure
___ ___ Low Blood Pressure
___ ___ Irregular Heartbeat
___ ___ Racing Heartbeat
___ ___ Heart Mumur
___ ___ Arm or Leg Pain
___ ___ High Cholesterol

Respiratory

Yes No

___ ___ Chronic Cough
___ ___ Wheezing
___ ___ Emphysema
___ ___ Bronchitis
___ ___ C O P D
___ ___ Shortness of Breath
___ ___ Oxygen Use at Home
___ ___ Pneumonia
___ ___ Lung Cancer
___ ___ Tuberculosis
___ ___ Blood in Saliva

Ears, Nose, Mouth and Throat

Yes No

___ ___ Hearing Loss
___ ___ Hearing Aid
___ ___ Ear Infections
___ ___ Pressure in Ears
___ ___ Ringing in Ears
___ ___ Pain in Ears
___ ___ Itching in Ears
___ ___ Dizziness
___ ___ Nasal Congestion
___ ___ Nasal Drainage
___ ___ Nosebleeds
___ ___ Sinus Problems
___ ___ Sinus Infections
___ ___ Throat Infections
___ ___ Difficulty Swallowing
___ ___ Lip or Mouth Sores
___ ___ Bad Breath

Gastrointestinal

Yes No

___ ___ Blood in Vomit
___ ___ Heartburn
___ ___ Hepatits
___ ___ Jaundice
___ ___ Stomach Abdominal Pain
___ ___ Gastritis Stomach Ulcers
___ ___ Constipation
___ ___ Diarrhea
___ ___ Change in Bowel Habits
___ ___ Black or Stools
___ ___ Rectal Bleeding
___ ___ Hemorrhoids
___ ___ Stomach Liver Colon Cancer

Hematologic

Yes No

___ ___ Hemophilia
___ ___ Easy Bleeding or Bruising
___ ___ Swollen Gland
___ ___ Anemia

Genilurinary

Yes No

___ ___ Pain Burning with Urination
___ ___ Blood in Urine
___ ___ Urinary Infection
___ ___ Bladder or Kidney Infection
___ ___ Difficulty Urinating
___ ___ Incontinence
___ ___ Kidney Stones
___ ___ Prostate Enlargement
___ ___ Endometriosis
___ ___ Cervical or Ovarian Cancer
___ ___ Uterine Cancer

Neurologic

Yes No

___ ___ Disorientation
___ ___ Fainting Blackout Spells
___ ___ Light Headedness
___ ___ Seizures
___ ___ Stroke
___ ___ Mini Stroke or TIA
___ ___ Memory Problems
___ ___ Concentration Problems
___ ___ Speech Problems
___ ___ Facial Weakness Spasms
___ ___ Muscle Weakness
___ ___ Coordination Problems
___ ___ Uncontrolled Shaking
___ ___ Headache or Migraine

Endocrine

Yes No

___ ___ Diabetes
___ ___ Hormone Problems
___ ___ Low Blood Sugar
___ ___ Thyroid Disease
___ ___ Increased Appetite
___ ___ Excessive Thirst
___ ___ Excessive Urination
___ ___ Temperature Intolerance
___ ___ Pituitary Gland Problems

Immunologic

Yes No

___ ___ Frequent Colds Infections
___ ___ Hay Fever
___ ___ Food Allergies
___ ___ Immune System Problems
___ ___ Connective Tissue Disease
___ ___ Environmental Allergies

Skin

Yes No

___ ___ Eczema Psoriasis
___ ___ Dermatitis
___ ___ Dry or Scaling Skin
___ ___ Rashes
___ ___ Changes in Skin Color
___ ___ Skin Cancer
___ ___ Breast Pain or Swelling
___ ___ Nipple Discharge

Musculoskeletal

Yes No

___ ___ Back Pain
___ ___ Arm or Leg Pain
___ ___ Joint Pain or Swelling
___ ___ Broken Bones
___ ___ Arthritis

Psychiatric

Yes No

___ ___ Anxiety
___ ___ Depression
___ ___ Considering Suicide
___ ___ Panic Attacks
___ ___ Sudden Mood Swings
___ ___ Emotional Difficulties
___ ___ Insomnia
___ ___ Other Psychiatric Problems
___ ___ Under Psychiatric Care
___ ___ Desiring Psychiatric Help

David A. Sherris, MD

Health History questionnaire- Past Family and Social

Date _____ Last Name_____First_____

Date of Birth _____

Any serious problems in the last five years? Check all that apply

___ Gallbladder Surgery ___ Hysterectomy and relate surgery

___ Appendectomy ___ Lung Surgery(ies)

___ Breast Surgery(ies) ___ Nose Surgery (ies)

___ Cardiac surgery(ies) ___ Orthopaedic surgery(ies)

___ Colon surgery (ies) ___ Prostate Surgery

___ Eye Surgery (ies) ___ Stomach Surgery (ies)

___ Gallbladder Surgery ___ Vascular Surgery (ies)

Other Surgery (ies) Not Listed_____

_____

Anything you do that might affect your health?

___ Yes ___ No I smoke or Chew Tobacco

___ Yes ___ No I drink alcoholic beverages

___ Yes ___ No I drink coffee, tea or soda pop

___ Yes ___ No I use street drugs

___ Yes ___ No I don't get much exercise

___ Yes ___ No I eat lots of fatty foods

___ Yes ___No I eat lots of salty foods

___ Yes ___ No I have lots of stress at work

___ Yes ___ No I have stress in my personal life

___ Yes ___ No I work in a noisy environment

___ Yes ___ No I work in a dusty environment

Medical Conditions that we need to be aware of:

___ None

___ Yes ___ No Diabetes Insulin Dependent

___ Yes ___No Diabetes Non-Insulin Dependent

___ Yes ___ No Heart Disease

___ Yes ___ No Hepatitis

___ Yes ___ No Hypertension

___ Yes ___ No Taking Blood Thinners

___ Yes ___ No Liver Complications

___ Yes ___ No HIV + or AIDS

Medical Conditions that we need to be aware of Continued:

___ Yes ___ No Cancer _____

___ Yes ___ No Lung Disease (Asthma, COPD etc.)

Serious Hospitalizations, Unrelated to Surgery

None ___ Reason Hospitalized (non-surgical) _____

_____

Serious Injuries, not already mentioned

None ___ Type of Injury _____

_____

Serious Illnesses, not already mentioned

None ___ Illness _____

_____

Tell us about each of the following blood relatives:

	Mother	Father	Sister	Brother	Maternal Grandparents	Paternal Grandparents
Allergies	___	___	___	___	___	___
Anemia	___	___	___	___	___	___
Asthma	___	___	___	___	___	___
Bleeding Tendency	___	___	___	___	___	___
Cancer	___	___	___	___	___	___
Chronic Lung Disease	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___
Epilepsy	___	___	___	___	___	___
Glaucoma	___	___	___	___	___	___
Heart Disease	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___
Kidney Disease	___	___	___	___	___	___
Leukemia	___	___	___	___	___	___
Migraine Headaches	___	___	___	___	___	___
Obesity	___	___	___	___	___	___
Sinus Disease	___	___	___	___	___	___
Stroke	___	___	___	___	___	___
Thyroid Disease	___	___	___	___	___	___
Tuberculosis	___	___	___	___	___	___
Ulcer	___	___	___	___	___	___

Date:_____

Patient Name: _____ **Birth date:**_____ **Age:** _____
First *Middle* *Last*

Address: _____ City: _____ State: _____ Zip:_____

Social Security #: _____ Female □ Male □

Home phone: _____Cell phone: _____ Work phone: _____

Primary Care Physician _____ **Primary Care Phone** _____

Employer: _____ Occupation:_____

Employer address: _____ FT □ PT □ Disabled □

Emergency contact: _____ **Cell phone** _____ **Home phone** _____

Relationship: _____Contact address: _____

Contact Information: May we contact your cell phone? □ Yes □ No **Cell phone:** _____

May we contact you at home? □ Yes □ No

If yes, may we leave a message? □ Yes □ No

May we contact you at work? □ Yes □ No

May we contact you via email? □ Yes □ No Email address: _____

Appointment Confirmation: May we confirm appointments by text message? □ Yes □ No

To confirm by text please provide cell carrier (ATT, Verizon etc.) Carrier: _____

Or we can confirm appointments by e-mail? □ Yes □ No Email: _____

Special Offers and Events: □ I am interested in learning about special events and exclusive offers □ Text □ Email

How did you hear about Dr. Sherris?

□ Website – drsherris.com □ Physician: _____ □ Family/ Friend:_____
Name Name

□ Online search □ Publication:_____ □ Seminar:_____
Name Name

□ Facebook: _____ □ Radio: _____

The Web is an important way for patients to learn about Dr. Sherris and our practice. Please let us know if you use any of the following?

□ Google+ □ Yelp □ Facebook □Twitter □ Pinterest □ RealSelf □ Instagram

□ Medical Review Sites: If yes, which one(s)? _____

□ Blogging: If yes, where can we see it? _____

What website(s) did you find helpful in researching our practice or the procedure? _____

INSURANCE SUBSCRIBER/ HEAD OF HOUSEHOLD- REQUIRED

Name:_____
First Middle Last

Address:_____ City _____State _____Zip Code _____

Home Phone#(_____)_____ Social Security #:_____ **Date of Birth:**___/___/_____

Employer:_____**Work Phone:**_____

Address:_____**Please Circle Status:** FT □ PT □

Your relationship to the insurance subscriber: Self Spouse Child Other_____

INSURANCE INFORMATION: (Please give your insurance cards to the receptionist for verification)

Name Primary Insurance: _____ **ID#** _____

Group #_____ **Effective Date:** _____

Name of Secondary Insurance: _____ **ID#**_____

Group # _____ **Effective Date:** _____

Name of Third Insurance: _____ **ID#** _____

Group # _____ **Effective Date:** _____

Fiscal Policy: All payments for office services are due on the date of service. This would include non-surgical treatments or any insurance co-pay or other insurance financial responsibility. Payment for any cosmetic surgery is required in full 2 weeks or more in advance of scheduled surgery. Insurance financial responsibility is due on any insurance procedures. If you are not aware of your possible insurance responsibility or plan coverage please contact your insurance carrier. Our complete financial policy is available on request.

Cancellation of appointments is required 48 hours prior to scheduled date or service fees may be charged. No Show Fees will be charged for any non-cancelled appointment. Cancellation of any insurance procedure 3 weeks or less prior to surgery will incur a rescheduling fee of $200. Cancellation of any cosmetic procedure for non-medical reasons 2-3 weeks from surgery date will incur a $1000 cancel fee. Less than 2 weeks prior will incur a 25% of surgery fee for non-medical reasons. Cosmetic surgery scheduling deposit of $500 is non-refundable regardless of cancellation date.

Assignment of Benefits: I authorize payment of medical benefits to Dr. David A. Sherris and the release of any medical information to process the payment of any insurance claim.

_____ _____
Signature of Patient or Authorized patient representative Date

_____
Printed Name relationship