Daniel C. Morello, MD, FACS

PATIENT INFORMATION

Name: _____
First Middle Last

Age: _____ DOB:_____/_____/_____ Social Security Number: _____-____-_____
Month Day Year

Address: _____
Street

_____
City State Zip

Email: _____

Home Phone: (___)_____ Work Phone: (___)_____Cell Phone: (____)_____

Primary Medical Doctor: _____
Ob/Gyn: _____
Referred by: Patient _____ Physician _____ Internet _____
Employer:_____Occupation:_____
Address: _____
Street

_____
City State Zip

Phone: (___)_____ Spouse's Name (if applicable) _____

MEDICAL INSURANCE INFORMATION

Name of person holding medical insurance (if different from patient): _____
Primary Insurance Company: _____
Insurance ID#: _____ Insurance Group#: _____
Secondary Insurance Company (if applicable)
Insurance ID#: _____ Insurance Group#: _____

*Please bring your insurance card to your appointment;
we will retain a copy to expedite processing of your benefits.

EMERGENCY CONTACT

Name: _____
Home Phone: (___)_____ Work Phone: (___)_____Cell Phone: (____)_____
Relationship: _____

FOR PATIENT'S UNDER AGE 18

Father's Name: _____ Mother's Name: _____
Employer: _____ Employer: _____
Work Phone: (___)_____ Work Phone: (___)_____
Soc Sec Number: _____-_____-_____ Soc Sec Number _____-_____-_____

MEDICAL HISTORY

Name: _____ Date: _____
First Middle Last

Age: _____ Sex: Male_____ Female_____ Race: _____ Height: _____ Weight: _____

Reason for visit: _____

PAST MEDICAL HISTORY List any medical conditions for which you have been treated:

_____

_____

_____

PAST SURGICAL HISTORY List any operations, including cosmetic, you have had:

_____

_____

_____

Do you have a history of: (Please check yes/no)

	Yes	No
Asthma		
Bleeding Disorders		
Blood Clots		
Breast Disease		
Cancer		
Contact Dermatitis		
Depression		

	Yes	No
GERD/Reflux/Ulcers		
Gout		
Heart Disease		
Hepatitis		
High Blood Pressure		
Hypoglycemia		
Kidney Disease		

	Yes	No
Latex Allergy		
Liver Disease		
Nervous Disorder		
Thyroid Disease		
Tuberculosis		
Seizures		
Other:		

If yes to any of the above, please elaborate: _____

_____

Are there ANY other conditions we should know about? _____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? _____ If yes, how many packs per day? _____ How many years?_____
Have you ever smoked? _____ When did you stop? _____
Alcohol Use (Please Check): ____None ____ Social ____ Daily
Exercise (Please Check): ____Never ____ 1-4x per week ____ 4-6x per week
Drug Use:_____ Tranquilizers:_____ Diet Pills:_____

FAMILY HISTORY Has any family member had any of the following:
____ Heart attack ____ Cancer ____ High Blood Pressure ____ Breast Cancer
____ Diabetes ____ Abnormal reaction to general anesthesia
If yes, please elaborate:_____

_____

Please list all **MEDICATIONS** and **dosage** recently or regularly taken (include herbal and vitamins):

_____ _____
_____ _____
_____ _____

Please list any **ALLERGIES** to any **medications:** _____
_____

Please list any **NON-MEDICINE ALLERGIES** (i.e. latex, seasonal):_____
_____

WOMEN'S HEALTH

Have you ever been pregnant: _____ How many times: _____
Do you have children: _____ How many: _____
Date of Last Menstrual Period _____
Are you certain you are NOT pregnant? ____ Yes ___ No
Do you take oral contraceptive pills? ___ Yes ___ No
Date of most recent MAMMOGRAM: _____ Results: _____
Breast augmentation/reduction patients: Current bra size: _____ Desired bra size: _____

REVIEW OF SYSTEMS

Please check any of the following conditions that pertain to you:

General: ___Weight Changes ____Fatigue ___Chills ___Fevers
Head and Neck: ___Eye Pain ___Glaucoma ___Excessive Tearing ___Dry Eyes
___Inability to wear contact lenses (if applicable) ___Red Eyes
___Ear Pain ___Dizziness ___Hearing Loss ___Dentures
___Difficulty breathing through nose ___Sinus Problems
Cardiovascular: ___High blood pressure ___Chest Pain ___Shortness of Breath
___Irregular heartbeat ___ Extremity Swelling
Pulmonary: ___Asthma ___ Shortness of Breath ___ Recent Cough
Gastrointestinal: ___Ulcers ___Reflux ___Jaundice ___Change in color of stool
Genitourinary: ___Urinary tract infections ___ Kidney stones
Skin: ___New or changing lesions on the skin ___Previous skin cancer
Hematologic: ___Abnormal bleeding ___Easy bruising
Endocrine: ___Diabetes ___Thyroid abnormalities
Neurologic: ___Seizures ___Strokes ___ Sensory Loss
Psychiatric: ___Depression ___Alcoholism ___Anxiety
Mucsculoskeletal: ___Pain in extremities ___Joint Pain ___Extremity Swelling
If yes to any of above, please explain: _____
_____

YOUR SAFETY IS OUR FIRST PRIORITY. Thank you for your time.

PLEASE FAX COMPLETED DOCUMENTS TO (561) 296-4156
OR POSTAL MAIL TO 641 University Blvd, Ste 103, Jupiter, FL 33458