JRK Surgical PLLC

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female SS#: _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation:_____

Email Address: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____ Main Contact #: _____

Preferred Pharmacy: _____ City: _____ Phone #: _____

Intersection: _____

INSURANCE INFORMATION

Primary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

MEDICAL HISTORY

NAME: _____ _____ _____ **D.O.B.** ____/____/_____
LAST FIRST M.I.

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

_____

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name:_____ Phone #:_____ Fax #: _____

Address:_____ City:_____ State/Zip:_____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of_____packs/day for_____years. I quit in_____(year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack	☐	☐	
Diabetes	☐	☐	
Prostate cancer	☐	☐	
Kidney cancer	☐	☐	
Kidney stones	☐	☐	
Other significant disease	☐	☐	