# Mark C. Horattas, MD, FACS
## General Surgery, Endocrine Surgery, Endoscopy

| | | | |
|---|---|---|---|
| Patient Name: | Birth Date: | Age: | Today's Date: |
| Address: | | Patient Soc. Sec. #: | |
| City: State: Zip: | | Home Phone: Cell Phone: Work Phone: | |
| Patient's Employer: | Spouses's Employer: | | |
| Marital Status: | Spouse's Name: | Spouse's Birthdate: | Spouses's Soc. Sec. No: |
| Referred By: | Primary Care Physician: | | |
| Email Address: | | | |
| Have you had any recent testing done such as blood work, x-rays, scans?<br>If yes, please provide the name of the test, the facility where you had them taken and the date of each exam. | | | |
| Problem for which You are seeing Dr. Horattas for: | Duration of symptoms: | Patient's weight/height: | |

**PRIMARY INSURANCE**

Company Name: ______________________ Relationship to Patient: _______________

Name of Insured: ____________________

Insured's Date of Birth: ______________

**SECONDARY INSURANCE**

Company Name: ______________________ Relationship to Patient: ______________

Name of Insured: ___________________

Insured's Date of Birth: ______________

AKRON GENERAL

**H&P not valid if completed > 30 days prior to date of service.**

**Reason for Visit** *(patient's own words)*: ______

In case of emergency, contact: ______ Relationship: ______ Phone: ______

Living arrangements: ☐ Lives Alone ☐ Live with family at home ☐ Live in extended care facility ☐ Other: ______

Do you plan to return to current living arrangement? ☐ Yes ☐ No, explain: ______

Do you need help in caring for yourself? ☐ No ☐ Yes, explain: ______

Do you need / use medical equipment at home? ☐ No ☐ Yes, explain: ______

Health Habits: Alcohol? ☐ Yes ☐ No Number of drinks per day: ______ Quit: ______

Tobacco? ☐ Yes ☐ No Number per day: ______ Number of years: ______ Quit: ______

Recreational Drug Use? ☐ Yes ☐ No Substance: ______ Frequency: ______ Quit: ______

Have you had any recent exposure to communicable disease (TB, chicken pox, measles, Venereal Disease, etc.?)
☐ No ☐ Yes, explain: ______

Do you have cultural /religious requests? ☐ No ☐ Yes, explain: ______

Immunizations current? ☐ Unknown ☐ Yes ☐ No, explain: ______

Are you currently in a situation or relationship in which you feel unsafe? ☐ No ☐ Yes, explain: ______

**Anesthesia:** Have you or family members had problems with anesthesia? ☐ No ☐ Yes, explain: ______

Do you or family members have any history of Malignant Hyperthermia? ☐ No ☐ Yes, explain: ______

Has any anesthesia provider told you it was difficult to place a breathing tube? ☐ No ☐ Yes, explain: ______

Are you able to climb a flight of stairs without getting short of breath or having chest pressure/pain? ☐ Yes ☐ No

| Year | Procedure, Hospitalization, Dental, etc. | Year | Procedure, Hospitalization, Dental, etc. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Allergies:** ☐ See Allergy Assessment Form ______

**Current Medications** (include over-the-counter, herbs, vitamins, home remedies, etc.): ☐ Unable to give medication history.

| Medication | Dose | How Often | Medication | Dose | How Often |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Pain:** Rate 0 - 10: ______ Location: ______ How long: ______ How often: ______

What helps pain? ______ What aggravates pain? ______

**Review of Systems** (please check all that apply, S = Self, F = Family:): ☐ Blind: ☐ Right ☐ Left ☐ Glasses ☐ Contacts ☐ Glaucoma

☐ Hearing Aid(s): ☐ Right ☐ Left ☐ Dentures: ☐ Upper ☐ Lower ☐ Prosthetic Device: ______

Are you currently pregnant? ☐ No ☐ Yes Last monthly period: ______

| S | F | | S | F | | S | F | | S | F | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Sinus Problems | ☐ | ☐ | Peripheral Vascular Disease | ☐ | ☐ | Limited support system | ☐ | ☐ | Dialysis |
| ☐ | ☐ | Excessive Snoring | ☐ | ☐ | Blood clots/Phlebitis | ☐ | ☐ | Alzheimers/Dementia | ☐ | ☐ | Ulcer |
| ☐ | ☐ | Sleep Apnea | ☐ | ☐ | Diabetes | ☐ | ☐ | Rash | ☐ | ☐ | Bowel Problems |
| | | ☐ CPAP ☐ BIPAP | ☐ | ☐ | Insulin Pump | ☐ | ☐ | Asthma | ☐ | ☐ | Ostomy, type: ______ |
| ☐ | ☐ | Chest pain/Angina | ☐ | ☐ | Hepatitis | ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ | Muscle weakness |
| ☐ | ☐ | High blood pressure | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | TB | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Heart Failure | ☐ | ☐ | Mental Health Disorder | ☐ | ☐ | Cough | ☐ | ☐ | Bleeding tendency |
| ☐ | ☐ | Pacemaker/ICD | ☐ | ☐ | Anxiety | ☐ | ☐ | Prostate Problems | ☐ | ☐ | Seizures |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Depression | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Stroke / TIA |
| ☐ | ☐ | Carotid Artery Disease | ☐ | ☐ | Trouble coping | ☐ | ☐ | Urinary Problems | ☐ | ☐ | Fainting |

☐ ☐ Cancer, type: ______ Treatment: ______

Patient / Representative Signature: ______ Date: ______ Time: ______

☐ Information reviewed. Staff Signature: ______ Date: ______ Time: ______

(E.F. 100-007) (Rev. 060414)

**PATIENT HEALTH HISTORY / PHYSICAL**

*(Page 2 of 2)* Chart Copy

TAB (SALMON/BEIGE): HISTORY & PHYSICAL

WELCOME TO OUR OFFICE!

As a courtesy, we will send claims to your primary and secondary insurance for you. In order for claims to be filed properly, please read and sign the following release of information and fill out the entire reverse side of this form carefully.

If your insurance coverage has a co-pay amount for office visits, we will collect the co-payment amount at the time of your visit.

Thank you for your cooperation.

INSURANCE AND AUTHORIZATION ASSIGNMENT:

I understand my signature requests that payment be made and authorizes release of any medical information necessary to pay that claim. I authorize payment of medical benefits directly to Mark C. Horattas, M.D. I understand I am responsible for any balance not covered by my insurance and payment for all professional services rendered is my responsibility.

RELEASE OF MEDICAL RECORDS:

My signature will also serve as a release of my medical records, test results, x-rays, etc. to this office or, if necessary, also authorizes Mark C. Horattas, M.D. to release information about me to other doctors, medical facilities, or insurance companies.

A photocopy of this assignment will be considered as valid as the original.

SIGNED: ____________________________________ DATE: ___________________