Northside Gwinnett Surgical Associates
Patient Registration

Your Name: _____ **Date of Birth:** _____

TODAY'S VISIT

Referring Physician: _____ Phone #: _____
Reason for Today's Visit: _____

Preferred Pharmacy Name: _____

Drug Allergies:_____

Medications and Dosage being taken:

_____
_____
_____
_____

Do You Smoke?(Circle One) YES NO If yes, how long?_____ How many per day? _____
Alcohol Intake? (Circle One) YES NO If yes, how often? _____

MEDICAL HISTORY

Respiratory Doctor's Name: _____
Please circle all that apply: Sleep Apnea COPD Asthma Bronchitis Pulmonary Embolus
Lung Cancer Tuberculosis Pneumonia Shortness of Breath/Cough Cough up Blood

Cardiovascular Doctor's Name: _____
Please circle all that apply: Heart Attack (when?_____) Coronary Artery Disease Heart Failure/CHF
Abnormal EKG Arrhythmia Pacemaker/Defibrillator Angioplasty/Stent Heart Valve
Angina/Chest Pain Stroke Hypertension High Cholesterol Blood Clot/DVT
Leg Swelling Pain with Walking Non-Healing Wounds Varicose Veins

GI Doctor's Name: _____
Please circle all that apply: GERD Weight Loss Blood in Stool Constipation Change in Bowel Habits

Endocrine Doctor's Name: _____
Please circle all that apply: Diabetes Diet/Pill/Insulin/Pump Thyroid Disease Hypo/Hyper Abnormal Calcium Level

Prior Surgery, Illness, or Injury and Complications: _____
_____
_____

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____