



ANNE PELED, MD

GENERAL HISTORY FORM

IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____ Age: _____ Date of Birth: _____ Weight: _____ Height: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail address: _____
Emergency Contact Name: _____
Emergency Contact Cell Phone: _____ Emergency Contact relationship to you _____
Occupation: _____ Employer: _____
Reason for today's visit: _____

Primary Care Physician: _____ City: _____

Referring Physician: _____ City: _____ None

Are there other physicians involved in your care whom you'd like to receive your notes?:

Physician Name: _____ Specialty: _____ City: _____

Physician Name: _____ Specialty: _____ City: _____

How Did You Hear About Us? _____

Primary Insurance: _____

Policy Holder: _____

Is this insurance through Brown & Toland Medical Group? Yes No

Secondary Insurance: _____

Policy Holder: _____

PAYMENT OPTIONS:

- MasterCard & Visa are accepted
- Personal checks are accepted at least 14 days prior to surgery



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Do you **currently** have any of the following conditions?

	YES	NO		YES	NO		YES	NO
EYES			ENDOCRINE			GENITOURINARY		
NONE	<input type="checkbox"/>		NONE	<input type="checkbox"/>		NONE	<input type="checkbox"/>	
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain w/ urination	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance(s)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with pills	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with diet	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, THROAT			Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
NONE	<input type="checkbox"/>		CARDIAC			MUSCULOSKELETAL		
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	NONE	<input type="checkbox"/>		NONE	<input type="checkbox"/>	
Chronic sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Nasal breathing issues	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disk	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
NONE	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Use oxygen at home	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGIC		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac bypass	<input type="checkbox"/>	<input type="checkbox"/>	NONE	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL			Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
NONE	<input type="checkbox"/>		High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Chronic nausea	<input type="checkbox"/>	<input type="checkbox"/>	HEME/LYMPH			SKIN		
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	NONE	<input type="checkbox"/>		NONE	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>	Moles	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>						
Hernia(s)	<input type="checkbox"/>	<input type="checkbox"/>						
Spleen problems	<input type="checkbox"/>	<input type="checkbox"/>						

PAST MEDICAL HISTORY:

Have you **ever** had any of the following?

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer (other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If yes to any of the above, please describe the condition: _____



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PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please describe the condition and identify your relation to the family member:

MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

NONE _____

DRUG ALLERGIES: _____ NONE

SOCIAL HISTORY:

Marital Status: _____ Spouse/Partner's name _____

Are you currently employed? yes ___ no ___ If so, what do you do? _____

Do you smoke? yes ___ no ___ If so, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____



ANNE PELED, MD

OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION

By my signature below, I am authorizing ANNE PELED, MD to bill my insurance company for services provided if applicable. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Peled will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. Finally, I understand that Dr. Peled may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by ANNE PELED, MD and I acknowledge that the difference will be my responsibility. I further acknowledge that any questions regarding these matters have been answered by Dr. Peled and/or her staff.

Printed Name

Signature

Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship



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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been presented with a copy of Anne Peled, MD's 'Notice of Privacy Practices' (ask Alexandra for a paper copy; they are also available online at all times at this address: <http://www.annepeledmd.com/forms.html>), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these 'Practices', and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Printed Name

Signature

Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship



ANNE PELED, MD

PHOTOGRAPHIC CONSENT

I hereby grant permission for the use of any of my photographic medical records including illustrations, images, and/or other imaging records to Dr. Anne Peled for the following uses:

** All identifiable characteristics will be omitted to protect patient privacy unless written consent is obtained from the patient. **

- Educational presentations/lectures to other physicians _____ Yes No
- Discussions with other patients about potential surgery outcomes Yes No
- Inclusion on practice website to show potential surgery outcomes Yes No

I also understand that I may withdraw this permission or limit it at any time by giving Dr. Peled written notice specifying the images I no longer want her to use (or that I do not want any of my images used). Dr. Peled will discontinue use of the designated images within 15 business days of receiving the written notice.

Patient Signature

Print Name

Date