Family/Primary Care Doctor: _____ Referring Doctor _____Pharmacy_____

Patient _____
(last) (first) (middle initial)

Date of Birth _____ **Social Security** #_____ **Sex :** Male Female

Mailing Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email address _____

Occupation _____ Employer _____

Marital Status: _____ **Language:** English Spanish French Other_____

Race: White African American Asian Other:_____

Ethnicity: Not Hispanic Hispanic or Latino Other:_____

Insurance_____ _____

If Insurance is associated with your Spouse, please fill out information

Spouse's Name _____ Spouse's DOB _____ Spouse's SS# _____

Spouse's Employer _____ Work Phone _____

Complete this box if patient is insured under a parent:

Father's Name _____ Mother's Name _____

Father's Work /cell phone _____ Mother's work/cell phone _____

Father's birthdate _____ Mother's birthdate _____

Address_____ Address_____

_____ _____

Relative or friend locally (not residing with you) for use in emergency

Name_____ Relationship _____

Home phone _____ cell phone _____ work Phone _____

Next of Kin

Name_____ Relationship _____ phone _____

Reason for visit _____

If injury, did it happen at home? _____ work?_____ Automobile?_____ Other _____ Date of injury_____

Were x-rays taken?_____ Where were xrays taken?_____

Signature _____ **Date** _____

NAME_____ **DATE OF BIRTH**_____

FAMILY HISTORY – circle all that apply

None Family History unknown. Adopted**.**

Anesthesia reactions**:**	Mother	Father	Brother	Sister	Grandparent
Bleeding tendencies**:**	Mother	Father	Brother	Sister	Grandparent
Skin Cancer**:**	Mother	Father	Brother	Sister	Grandparent
Breast Cancer**:**	Mother	Father	Brother	Sister	Grandparent
Other Cancer**:**	Mother	Father	Brother	Sister	Grandparent
Heart disease**:**	Mother	Father	Brother	Sister	Grandparent
Thyroid disease**:**	Mother	Father	Brother	Sister	Grandparent

SOCIAL HISTORY – circle all that apply

TOBACCO CIGARETTE SMOKING
Never Smoked
Current – Everyday Some days
Former Smoker **Quit in year** _____

SMOKE CIGARS CHEW TABACCO SMOKE A PIPE

ALCOHOL

Current –	Former -
None	None
Less than 1 drink per week	Less than 1 drink per week
1-7 drinks per week	1-7 drinks per week
More than 14 drinks per week	More than 14 drinks per week

COFFEE _____ cup(s) per day

DRUG USE

Current –	Former -
None	None
marijuana	marijuana
other:_____	other:_____

MARITAL STATUS Married Single Separated Divorced Widowed Partner

OCCUPATION _____ **Retired** **Disabled**

LEVEL OF EDUCATION College Post-graduate High school

LANGUAGE English Spanish French Other _____

RACE White African American Asian Other _____

ETHNICITY Non-Hispanic Hispanic or Latino Other _____

PAST SURGICAL HISTORY AND APPROXIMATE YEAR OF SURGERY

Appendectomy _____
Gall bladder removal _____
CABG _____
Coronary artery stenting _____
Coronary angioplasty _____
Pacemaker placement _____
Hysterectomy _____
Hernia repair _____
Prostatectomy _____
Knee replacement (Left Right Bilateral) _____
Hip replacement (Left Right Bilateral)_____
Breast lumpectomy w/ radiation(Left Right) _____
Breast lumpectomy without radiation(Left Right) _____
Bilateral Mastectomy with radiation (Left Right)_____
Breast reduction _____
Tonsillectomy _____
Thyroidectomy _____
Left Right thyroid lobectomy _____
Septoplasty _____
Rhinoplasty _____
Sinus surgery _____

COSMETIC

Breast augmentation - silicone saline _____
Breast lift _____
Facelift _____
Neck lift _____
Upper Blepharoplasty _____
Lower Blepharoplasty _____
Otoplasty _____
Laser resurfacing of face _____
Abdominoplasty _____
Liposuction _____
LASIK _____
RK _____

OTHER

NONE

_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY – circle all that apply

HEART
Hypertension (High blood pressure)
Hypercholesterolemia (High Cholesterol)
Coronary Artery Disease
Heart attack - year(s):_____
Coronary artery stenting year(s):_____
Atrial fibrillation
Other heart arrhythmia (irregular heartbeat)
Pacemaker
Congestive Heart Failure

LUNGS
COPD (chronic lung disease)
Bronchitis
Emphysema
Asthma
Obstructive Sleep apnea
TB

CIRCULATION
Anemia
Bleeding disorder
Blood clots
DVT (blood clot in leg)
Pulmonary embolism
GERD/reflux

GASTROINTESTINAL
Peptic Ulcer disease
Hepatitis - Type: A B C or unknown
Cirrhosis

EYE
Glaucoma
Cataracts
Lasik
RK

ENDOCRINE
Diabetes Type I
Diabetes Type II
Hypothyroidism (low)
Hyperthyroidism (high)

KIDNEY
Chronic kidney disease
Kidney failure
Kidney stones
UTI's

CANCER
Skin -
BCC
SCC
melanoma
unknown

Other Cancer
Type: _____
Year completed treatment:
Surgery: Yes No
Radiation: Yes No
Chemotherapy: Yes No

Type: _____
Year completed treatment:
Surgery: Yes No
Radiation: Yes No
Chemotherapy: Yes No

ENVIRONMENTAL ALLERGIES
Previous Allergy Testing - Yes No
Sensitive to: Trees
Grasses
Weeds
Mold
Pollens
Dogs
cats
Previous Allergy Shots – Yes No

CHEMICAL DEPENDENCY
Alcohol
Drugs – type:

INFECTIOUS DISEASE
Rheumatic fever
HIV disease

NEUROLOGIC
Seizure disorder
Stroke/TIA – year(s):

PSYCHIATRIC
Depression
Bipolar disorder
Anxiety
Other:_____

OTHER MEDICAL CONDITION(S) NOT LISTED

1._____
2. _____
3._____
4._____
5. _____

NONE

Name (Last, First, MI)_____ Date of Birth_____

Review of Systems Complete - Circle all that apply to you currently

Constitutional:
unexplained weight loss
fever
chills
night sweats

Eyes:
eye pain
vision changes
double vision
eye irritation
dry eyes
excessive tearing
red eyes
Contact lenses
sensitivity to light
other eye surgery
eyelid surgery

Ear Nose Throat:
hearing loss
ringing in the ears
dizziness
ear pain
ear drainage
past nasal trauma
post nasal drip
difficulty breathing through nose

Ear Nose Throat Cont.:
sinus infections
past nasal or sinus surgery
dental problems
tooth pain
oral cancers
dentures
capped teeth
cold sores
voice changes

Cardiovascular:
chest pain
irregular heartbeat
heart murmur
heart surgery

Respiratory:
shortness of breath
use of oxygen
recent cough

Gastrointestinal:
heartburn
indigestion
vomiting
difficulty swallowing solids
difficulty swallowing liquids

Gastrointestinal Cont:
diarrhea
constipation
blood in stools
black stools
change in bowel habits
jaundice

Genitourinary:
pain urinating
difficulty urinating
frequent urination

Musculoskeletal:
bone or joint injuries
swelling
extremity pain
joint pain
arthritis
leg cramps
difficulty walking
weakness in arms or legs

Integumentary/Skin:
new or changing lesion(s)
rashes
cold sores
herpes

Neurologic:
sensory loss/numbness
weakness
seizures
headache
fainting spells
head injury

Psychiatric:
alcoholism
drug abuse
anxiety
marital problems

Hematologic/Lymphatic:
bleeding disorders
anemia
easy bruising
bleeding gums
swollen lymph nodes

Allergic/Immunologic:
season allergies
hay fever

Women's health:
pregnant
trying to get pregnant

MEDICATION ALLERGIES	**Reaction**

CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS	**Dosage if known**	**Directions**

Last Name, First Name, MI_____Date Of Birth _____

Purpose: This form is used to confirm that individual has received our Notice of Privacy (Blue Page)

I , _____, acknowledge that I have received Bruce V. Lattyak, M.D., Inc. Physician Practice's Notice of Privacy Practices. I have had a full opportunity to read and consider the contents of this Notice of Privacy Practices.

X Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's name: _____Relationship _____

FINANCIAL POLICY (Red Page)

I understand that medical insurance plans vary and there may be limitations and exclusions in my plan of which I or Dr. Lattyak may not be aware. I also understand that actual benefits can be determine only by my insurance company and only after a claim is filed. This applies to all medical coverage including Medicare and Medical. I agree to be responsible for the charges not covered by my insurance plan.

Patient Name:_____

X Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's name: _____Relationship _____

PHOTOGRAPHY CONSENT

I consent to the photographing of the treatment, procedure or for documentation of my care.

X Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's name: _____Relationship _____

NOTICE TO CONSUMERS

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