LUMIRI SURGICAL

Dr. Tiffany Schatz
19 Shelly Lane, Fort Washington, PA 19034
Phone: (215) 695-2777 Fax: (215) 695-2052

Date:_____

Patient Name:	Date of Birth:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
Contact Preference: ☐ Home ☐ Cell ☐ Email		
SSN:	Nickname:	
Race:	Ethnicity:	Gender:
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Religion:	Sexual Orientation:	

Emergency Contact Name:	
Relationship:	Phone:
Primary Care Doctor:	Phone:
Referring Doctor:	Phone:

Primary Insurance:	
Policy Holder:	Relationship:
SSN:	Date of Birth:
Subscriber ID:	Group Number:

Secondary Insurance:	
Policy Holder:	Relationship:
SSN:	Date of Birth:
Subscriber ID:	Group Number:

Local Pharmacy:	Phone:	
Address:		
City:	State:	Zip:
Mail Order Pharmacy:	Phone:	

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Pre-history information

Date:_____

How did you hear about us? _____

Referred by: _____

1. State in your own words the major medical reason(s) for seeking care now:

_____

_____

2. Please list all medications that you use, including vitamins and supplements.
If you brought a list, please write "See Attached":

Medication name	Dosage	Times per day	Reason for taking	When started

3. Do you have any allergies or reactions to medication?: ☐ Yes ☐ No

If yes, please list:_____

4. Family History: please indicate the health or cause of death of members of your family as best as you can:

	Age if Living	Age at Death	Indicate any serious diseases	Cause of death
Mother				
Father				
Brothers				
Sisters				
Other				

5. Please indicate which of your **immediate relatives**, if any, has any of the following diseases:

Cancer:	Diabetes:
Heart Problems:	High Blood Pressure:
Kidney Disease:	Stroke:
Mental/Emotional Problems:	Tuberculosis:

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Arthritis:	Other:

6. Your (patient) health conditions. Please comment on special problems and indicate approximate dates:

Yes	No	Nature of condition	Comments/Approx. Onset Dates
		Recent weight loss	
		Headaches	
		Trouble with vision	
		Trouble with hearing	
		Allergies to medications	
		Hay fever/seasonal allergies	
		Asthma	
		COPD/emphysema	
		Lung problems (pneumonia, TB, etc)	
		Shortness of breath, cough, wheeze	
		Thyroid problem	
		Diabetes	
		Skin problems	
		Anemia/abnormal bleeding	
		Heart problems	
		Chest pain	
		High blood pressure	
		Palpitations	
		Liver disease/infection, jaundice	
		Gallbladder disease, gallstones	
		Stomach problems, acid reflux, ulcers	
		Digestive issues: change in bowel habits, constipation, diarrhea	
		Abdominal pain	
		Blood in stool	
		Kidney/urinary problems	
		Joint pain/stiffness/arthritis	
		Seizures	
		Stroke	
		Depression/anxiety	
		Psychiatric illness	
		Other illnesses	

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7. Please give details of any of the following:

Surgery/serious injury	Approximate dates:	Surgeon:	Hospital:

8. Lifestyle:

Yes	No	Nature	Comments
		Do you drink coffee? How much?	
		Do you smoke? How much? How many years?	
		Do you drink alcohol? How many per week? Per day?	
		Do you use illicit drugs? What kind? How often?	

9. Home and Social Support:

Yes	No	Nature	Comments
		Do live with others? Who lives with you?	
		Do you have pets?	
		Do you have to use stairs at home? How many?	
		Do you have social support?	
		Do you feel safe at home?	

PLEASE FILL OUT ALL PAGES OF THIS FORM. IF YOU NEED ASSISTANCE, WE WOULD BE HAPPY TO ASSIST WITH COMPLETING THE FORMS.

Please feel free to attach any other recorded information, which you feel, will be of importance to the doctor in evaluating your health problems.