George Kouris, MD
&
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Today's Date _____

PATIENT INFORMATION:

Patient Name: _____ Sex: **F** **M**

Address: _____ Birth Date: _____

_____ Age: _____

Home Phone: _____ SS#: _____

Work Phone: _____ Marital Status: **S** **M** **W** **D**

Cell Phone: _____ Height: _____ Weight: _____

Would you be interested in receiving our newsletter via email? □ Yes □ No Email:_____

WHAT IS YOUR REASON FOR THIS VISIT? _____

GUARANTOR INFORMATION: (Responsible party)

Primary Insurance:_____ID#: _____
Subscriber Name:_____Group#: _____
Relationship to patient: _____ Birth Date: _____
Employer Name: _____SS#: _____
Secondary Insurance:_____-ID#: _____
Subscriber Name:_____Group#: _____
Relationship to patient: _____Birth Date: _____
Employer Name: _____SS#: _____

PHYSICIAN / EMERGENCY INFORMATION:

Family Physician:_____Office #: _____
Address:_____
_____
Emergency Contact:_____Phone #: _____
Relationship:_____
Who referred you to Dr. Kouris? _____Phone #: _____

PHARMACY INFORMATION:

Pharmacy Chain: _____Phone #: _____

ALLERGIES TO MEDICATIONS:

Yes___ (Please list below) No___

Name of medication	Reaction

FAMILY HISTORY(eg cancer or hereditary diseases)
Please indicate MATERNAL or PATERNAL

Family member	Disease	Cause of death

MEDICATION (prescription, supplements, vitamins and over the counter)

NAME OF MEDICATION	REASON FOR TAKING	NAME OF MEDICATION	REASON FOR TAKING

Please circle if you take any of the following: **COUMADIN** **PLAVIX** **LOVENOX** **ASPIRIN** **IBUPROFEN**

SOCIAL HISTORY:

Do you have children? Yes___ No___ If yes, how many daughter(s)_____ sons(s)_____
Who do you live with?_____
Do you work? Yes___ No____ What type of work do you do or did you do if you are retired?_____

HEALTH HABITS:

Do you smoke or have you ever smoked cigars/cigarettes? Yes___ No___ How many per day?_____
For how long?_____ Year quit(if applicable)_____
Do you drink alcohol? Yes___ No___ How many drinks per week?_____
Have you recently used any recreational drugs? Yes___ No ___ Explain:_____
Do you consume caffeine? Yes___ No___ What type and how much per day?_____
Have you ever had a mammogram? Yes___ No___ When?_____ Results: Normal_____ Abnormal_____
Have you ever had a breast biopsy? Yes___ No___ When?_____ Side: Left____ Right____
Results: Normal:_____Abnormal:_____ Explain:_____

MEDICAL HISTORY (Please circle those that apply to you):

Diabetes	Heart Failure	Heart Murmur	Previous Heart Attack Date:_____
Irregular heart beat	Rheumatic fever	High Cholesterol	High blood pressure
Asthma	Tuberculosis	Bronchitis	Pneumonia
Emphysema	Sleep Apnea	Arthritis	Thyroid disorder
Reflux	Hiatal Hernia	Peptic Ulcer Disease	Hepatitis
Cirrhosis	Diverticulosis	Hernia	Kidney Failure
Incontinence	Stroke	Headaches	Anxiety
Depression	Anemia	HIV/AIDS	**NO KNOWN HEALTH PROBLEMS**

Cancer Type of Cancer:_____Other:_____
Do you have any metal implants? Yes___No___ Do you have a pacemaker/defibrillator? Yes:___No:___

SURGICAL HISTORY: _____No surgeries in the past

SURGERY	DATE	SURGERY	DATE

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE EXPERIENCED IN THE LAST 6 MONTHS:

Reproductive	**Neurologic/Psych**	**Endocrine**	**Gastrointestinal**	**Gastrointestinal**
Nipple discharge	Loss of consciousness	Cold intolerance	Abdominal pain	Indigestion/heartburn
Breast mass	Numbness/tingling	Heat intolerance	Diarrhea/constipation	Difficulty swallowing
Breast pain	Seizures	Excessive thirst	Nausea	Excessinve bloating
Testicular mass	Dizziness	Excessive hunger	Vomiting	Difficulty holding
Testicular pain	Change in mood	Excessive urination	Blood in stool	stool

Respiratory	**Muscoloskeletal**	**Cardiovascular**	**Hematologic**	**Constitutional**
Wheezing	Bone pain	Chest pain	Blood clots	Fever
Blood in sputum	Joint pain	Palpitations	Easy bleeding	Weight loss
Chronic cough	Back pain	Pain in legs w/ walking	Easy bruising	Fatigue
Shortness of breath	Weakness	Pain/swelling in legs	Bleeding gums	Change in appetite
				Night sweats

Immunologic	**Dermatologic**	**Genitourinary**	**Eyes, ears, nose, & mouth**	
Environmental allergies	Rash	Blood in urine	Discharge from eyes	Vision loss
Food Allergies	Itching	Burning with urination	Discharge from ears	Hearing loss
	Hair loss	Frequent urination	Facial pain/sinusitis	Tooth pain
		Change in urine color	Hoarseness	Headache

NO KNOWN HEALTH PROBLEMS

I hereby authorize the physician to treat my daughter / son / myself. (Please circle appropriately)

Patient/Parent/Guardian _____ **Date** _____

ALL INFORMATION REVIEWED WITH PATIENT/PARENT/GUARDIAN

Doctor/Staff Member _____ Date _____