SURGICAL SPECIALISTS OF NORTHERN VIRGINIA

Surgery Evaluation Form: Please fill out completely & print clearly. Date: _____

First Name Middle Last

Birthdate: Age: Height: Weight:

Who referred you to our practice? _____
Who is your primary care physician? _____
Reason for Visit: _____ **Duration:** _____

Preferred Pharmacy: (Name, City & Phone #) _____

List other physicians you are seeing:

Physician Name:	**Specialty:**

Allergies: Medications, food, environmental, latex, adhesive **List Reaction:**

Medications: (List all current medications)

Date Started	Medication & Dose	Directions	Reason for Taking	Prescribed by

Please list any surgeries: (Please write year of surgery and type)

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Do you have a pacemaker or implanted device? If so, please list: _____

_____

_____J.Lesniewski _____D.Meikle _____M.Peters _____S.Hota

Past Medical History: (Please circle any past medical history and/or list under other)

Attention Deficit Disorder	**Dizziness/Vertigo**	**High cholesterol**	**Pneumonia**
Alcohol Disorder/Drug addiction	**Easy Bleeding**	**Hiatal Hernia**	**Psoriasis**
Anemia	**EKG (list year) _____**	**HIV Infection**	**Reflux**
Arrhythmia	**Emphysema**	**Hodgkin's Disease**	**Rheumatoid Arthritis**
Arthritis	**Epilepsy**	**Insomnia**	**Seizure Disorder**
Asthma	**Esophageal Reflux**	**Kidney Dialysis**	**Sickle Cell Disease**
Artificial joints	**Fatigue**	**Kidney poor function**	**Skin Disease**
Back Problems	**Fibromyalgia**	**Kidney stones**	**Sleep Apnea**
Blood clots in legs	**Gallstones**	**Leukemia**	**STDs**
Bronchitis	**Gastrointestinal Disorder**	**Lung disease**	**Stomach Ulcers**
Cancer (list type)	**Glaucoma**	**Lupus**	**Stroke Syndrome**
Colon polyps	**Gout**	**Lyme Disease**	**Thyroid Disorders**
Concussion	**Headache**	**Melanoma**	**Tuberculosis**
Congestive Heart Failure	**Heart Attack**	**Migraine or Headache** (circle which one)	**Ulcer disease**
COPD	**Hemorrhoids**	**Osteoporosis**	**Urinary tract infections**
Depression	**Hepatitis or Jaundice** (circle which one)	**Pancreatitis**	
Diabetes Mellitus	**High Blood Pressure**	**Other (List) _____**	

Family History: (All medical problems, surgeries, cancer and cause of death)

	Medical Problems	Surgeries	Cancer	Cause of death(age)
Mother:				
Father:				
Sisters:				
Brothers:				
Grandparents:				

Other: Please list any significant health issues with Aunts, Uncles, Cousins and Children. Please specify who has the specific issue**.** _____

_____

Review of Systems: (Please circle **ALL** symptoms within the **past 3 months** for each category below).

General/constitutional

Fever	Weight loss	Change in appetite	Headaches	Night sweats
Recent illness	Weight gain	Chills	Fatigue	Sleep disturbance

ENT

Sore throat	Nasal congestion	Sinus trouble	Difficulty swallowing	Eye problems
Dizziness	Nosebleed	Hearing		

Cardiovascular

Anemia	Easy bruising	Murmurs	Edema	Blood clots	Difficulty lying flat
Chest Pain	Ankle swelling	Swelling in Hands/Feet		Heart Palpitations	Shortness of Breath

Respiratory

Breathing problems	Cough	Wheezing	Coughing up Blood	Shortness of Breath

Gastrointestinal

Gas/bloating	Acid reflux	Hemorrhoids	Diarrhea	Indigestion
Lower abdominal pain	Heartburn	Nausea	Vomiting	Vomiting blood
Upper abdominal pain	Stomach problems	Rectal pain	Rectal Bleeding	

Genitourinary

Urine leakage	Kidney stones	Large prostate	Heavy uterine bleeding	Frequent urination
Erectile dysfunction	Painful urination		Difficulty urinating	

Musculoskeletal

Back pain	Arthritis	Neck problems	Limb weakness	Leg cramps	Muscle aches	Joint stiffness

Neurologic

Seizures	Tingling	Numbness	Loss of consciousness	Loss of balance

Psychological

Anxiety	Depressed Mood	Fear/phobia	Treatment for emotional or psychiatric disorder
Auditory/visual hallucinations			

Skin

Hives	Skin Rashes	Skin Lesions

Social History: (Please write and/or CIRCLE the appropriate answer)

Who lives with you? _____

Occupation: _____

Do you smoke? Yes No Former **How much?** _____

What do you smoke? (i.e., cigars, cigarettes, marijuana) _____

Do you drink alcohol? Yes No Former **How often?** Daily Weekly Monthly Social

Do you use recreational drugs? Yes No Former **Type and extent of use:** _____

Are you pregnant? Yes No **Date of last menstrual cycle?** _____

James A. Lesniewski, M.D.
Michael J. Peters, M.D.
Daniel L. Meikle, M.D.
Salini S. Hota, M.D.

Prefix: Mr./Mrs./Other: _____ Patient: _____ Suffix: Jr./Sr./Other: _____
Last First Middle Initial

Previous Name: _____ Preferred Name: _____

Mailing Address: _____
Street Address City State Zip

Home #: _____ Cell #: _____ Work #: _____ Social Security #: ____ - ____ - _____

Date of Birth: _____ Sex*: ____ Marital Status*: ___ Single ___ Married ___ Widowed ___ Separated ___ Divorced
mm/dd/yyyy

Employer Name: _____ Occupation: _____

Employment Status: ___ Full Time ___ Part Time ___ Not Employed ___ Self Employed ___ Retired ___ Active Military

Student Status: ___ Full Time ___ Part Time ___ N/A

Primary Care Physician: Name/Address/Phone**:** _____

Referring Physician: Name/Address/Phone**:** _____

Additional Information

Email: _____

Race: ___ Caucasian/White ____ Asian _____ Black/African American ____ Hawaiian/Pacific Islander ___ Other: _____

Ethnicity: ____ Hispanic or Latino ____ Non-Hispanic or Latino ____ Other: _____

Language: ____ English ____ Spanish ____ Other: _____

Pharmacy Name: _____ **Address:** _____ **Phone:** _____
Street Address City State Zip

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name: _____ Date of Birth: _____ Sex: _____ Social Security Number #: _____ - ___ - _____.
Last First

Mailing Address: _____
Street Address (if different from patient) City State Zip

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Insurance Name and Phone #: Primary: _____ Secondary: _____

****I hereby authorize the release of medical information via fax as may be deemed necessary by my physician regarding my medical care.**

****I allow you to speak to the following person(s), including my emergency contact, concerning my medical care.**

NAME / EMERGENCY CONTACT(S)	RELATIONSHIP	PHONE #

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis **Date**

****I hereby acknowledge and understand that if outpatient/inpatient surgery is required and I cancel or reschedule within 5 business days of scheduled surgery date, I will be charged a *$500.00 late cancellation fee.***

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis **Date**

Consent Information

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. **X _____ (Please initial)**

Notice of Deemed Consent for HIV, Hepatitis B or C Testing

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X _____ (Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X _____(Please initial)**

Consent for Health Information Exchange

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Send and Receive Documents. Please initial beside the option of your choice:

Opt In: X_____ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out: X_____ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

Medication History Consent

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X _____ (Please initial)**

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis **Date**

Loudoun Medical Group -- Receipt of Notice of Privacy Practices Acknowledgement

I, _____ (print patient name), acknowledge receiving on _____ (print date),
a copy of Loudoun Medical Group's Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis **Date**

FOR OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason:
		Refused to sign (circle if applicable) **Other:**