

Edward H.H. Garber, Jr., M.D., F.A.C.S. • Steven M. Pandelidis, M.D., F.A.C.S.
Dennis E. Johnson, M.D., F.A.C.S. • John S. Monk Jr., M.D., F.A.C.S.

Date: _____

Dear: _____

Please fill out the following paperwork at home and bring it with you to your appointment with Dr. Garber/Dr. Monk on:

Also bring your Insurance Cards, Insurance Referral (if one is required), list of medications and photo ID.

Please arrive 15 minutes before your appointment and have the enclosed paperwork completed. Due to the length of this initial consultation ***if you arrive late, do not have your referral or if your paperwork is not completed, you will be asked to reschedule your appointment.***

We look forward to meeting you.

Thank you for your cooperation.

Apple Hill Surgical Associates, Ltd.
25 Monument Road, Suite 220
York, PA 17403
717-741-0733 Fax: 717-741-3604

HEALTH QUESTIONNAIRE

DEMOGRAPHIC INFORMATION:

Name: _____

SSN: _____

Date of Birth: _____

Sex: _____

Age: _____

Marital Status: _____

Race/Ethnicity: _____

Address: _____

Phone: (Day) _____

Evening: _____

Occupation: _____

Employer/Address: _____

Insurance: _____

Policy Number: _____ Group No: _____

Spouse/Significant Other's Name: _____

Spouse's Employer/Address: _____

Spouse's Insurance: _____

Policy Number: _____ Group No: _____

Primary Physician: _____

Address: _____

Other Physicians you have seen: _____

Name _____ Date of Birth _____

Check all that apply.

Last physical exam _____

General:	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue
Head/Neck: <input type="checkbox"/> Glasses / contacts <input type="checkbox"/> Visual changes <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hearing loss / aids <input type="checkbox"/> Neck pain <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Neck lumps/bumps <input type="checkbox"/> Allergies / hay fever <input type="checkbox"/> Daily headaches	<input type="checkbox"/> Migraine type headache
Lungs: <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Use CPAP <input type="checkbox"/> Asthma (wheezing)	<input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Snoring <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Daytime sleepiness <input type="checkbox"/> Breathing problems <input type="checkbox"/> Cough	<input type="checkbox"/> Cough with mucous <input type="checkbox"/> Short of breath <input type="checkbox"/> Nose bleeds
Heart: <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart attack (MI) <input type="checkbox"/> Stroke <input type="checkbox"/> Heart failure <input type="checkbox"/> High cholesterol	<input type="checkbox"/> Had stress test for heart <input type="checkbox"/> Had heart cath <input type="checkbox"/> Poor circulation	<input type="checkbox"/> Swelling in legs <input type="checkbox"/> Blood clots <input type="checkbox"/> Chest pain, when walking <input type="checkbox"/> Chest pain, at rest	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Heart palpitations
Gastrointestinal: <input type="checkbox"/> Jaundice (Liver disease) <input type="checkbox"/> GERD (reflux/heartburn)	<input type="checkbox"/> Hepatitis – type _____ <input type="checkbox"/> Gallstones <input type="checkbox"/> Gallbladder removed <input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Black stools	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea (irritable bowel) <input type="checkbox"/> Change in bowel habits
Genital / Urinary: <input type="checkbox"/> Bladder control problem	<input type="checkbox"/> Kidney disease <input type="checkbox"/> Burning with urination	<input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Blood in urine	<input type="checkbox"/> Slow urine stream
Endocrine: <input type="checkbox"/> Diabetes (high blood sugar)	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Hot flashes	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Easy bruising
Women only: <input type="checkbox"/> Last mammogram _____ <input type="checkbox"/> Planning a future pregnancy	<input type="checkbox"/> Poly cystic ovary disease <input type="checkbox"/> Facial hair	<input type="checkbox"/> Date of last menstrual period _____ <input type="checkbox"/> Last female exam _____	<input type="checkbox"/> Heavy periods <input type="checkbox"/> Irregular periods
Musculoskeletal: <input type="checkbox"/> Arthritis (joint pain)	<input type="checkbox"/> Back pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Leg pain	<input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gout	<input type="checkbox"/> Hernia -- where? _____
Skin:	<input type="checkbox"/> Problem with excess skin	<input type="checkbox"/> Skin rash <input type="checkbox"/> Acne	<input type="checkbox"/> Rosacea <input type="checkbox"/> Skin cancer
Neurological: <input type="checkbox"/> Seizures	<input type="checkbox"/> Weakness <input type="checkbox"/> Numbness	<input type="checkbox"/> Tremor <input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting spells
Other:	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> HIV/AIDS	

List all previous hospitalization and surgeries

Type/Reason	Date	Hospital	Physician

Family History	Age/Age at Death	Ht / Wt	Medical Problems
Mother			
Father			
Brothers			
Sisters			
Children			

Does obesity run in your family? Yes No

Psycho-social:

- Depression
- Mental Health problems --what? _____
- Alcohol -- how often? _____
- Have you ever used tobacco? _____ How long? _____
How much tobacco do you use? _____
- Have you ever used illicit drugs? _____ What? _____

The above information is accurate and complete to the best of my knowledge:

Patient signature _____ Date _____

Provider signature _____ Date _____