Welcome to Shore Physicians Group Surgical Department.

Thank you for choosing us for your surgical specialty care. The enclosed packet contains important forms for completion prior to your visit - demographic information, a health questionnaire and a medical records release form. Please complete and return all forms to the office within 7 days. In order for us to deliver the best medical care possible, it is important that we have these forms and your medical records at the time of your visit. The team will also need your most recent and relevant laboratory results and imaging studies (CT scan, MRI, Mammogram films and discs, Ultrasound, Biopsy Reports and Pathology). If it is not possible to deliver all of this information within 3 business days of your appointment, please bring them on the day of your visit. Otherwise, it may be necessary to reschedule the appointment.

If you need a referral to see a specialist based on your health insurance carrier, please obtain this prior to your office visit. If you do not have the proper insurance referral that your health insurance requires, your appointment will need to be rescheduled.

Also, please bring a list of your current medications, dosages, and how you take them to your appointment.

Our cancellation/late policy is: If a cancellation is not made 24 hours prior to the scheduled appointment, you will be charged a No Show fee ($25). If you arrive more than 15 minutes late, your appointment may need to be rescheduled.

Communication with our office and/or the health care provider- we strongly recommend you sign up for our patient portal. We have included instructions for using the portal with this letter, and/or our team can help you with the instructions on signing on to the portal on the day of your appointment.

If you have any questions or concerns that we can assist you with, please do not hesitate to contact us at (609) 365-6239.

We look forward to seeing you and thank you for choosing Shore Physicians Group Specialty Consultants.

Shore Physicians Group Specialty Consultants
649 Shore Road, Somers Point, NJ 08244

Patient Name: _____ DOB: _____ Date: _____
Primary Physician: _____ Cardiologist: _____ Pulmonologist:_____
Pharmacy Name/Address/Phone Number: _____
Preferred Lab: _____ Preferred Radiology Facility: _____
Reason for Visit: _____ How long have you had symptoms: _____

Allergies: Please list all Drug/Food/Latex Allergies

Allergy	**Reaction**

Medication History: Please list all Current Medication you are taking (Med List Attached -- ❑Yes ❑No)

Medication	**Dosage**	**How Taken**

Vaccinations: Are you current with your vaccinations? ❑Yes ❑No

Date of Last Tetanus Shot _____ Date of Last Flu Shot _____

Family History: List Current or Past Medical Conditions of Mother/Father/Brother/Sister/Grandparents/Aunts/Uncles
Unknown Family History ❑Yes ❑No

Medical Condition	**Relative**	**Age of Onset**	**If Deceased Age and Cause of Death**
Cancer	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		
Diabetes	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		
Heart Trouble	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		
Hypertension	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		
Stroke	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		
Clotting Disorder	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		
Kidney Disorder	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		
Others	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U		

Social History: Please check the appropriate boxes, or complete as applicable:
Do you drink Alcoholic Beverages? ❑Never ❑ Rarely ❑ Moderately ❑Frequently
How many days in the past year have you had 4 or more alcoholic beverages on the same day? _____
Do you use Tobacco? ❑ Never ❑Former ❑Current Daily ❑Current Occasionally ❑Unknown
How much do you Smoke? ❑1PPW ❑2PPW ❑ ¼ PPD ❑ ½ PPD ❑1PPD ❑1 1/2 PPD ❑2PPD ❑3+PPD
Do you use the E-Cigarette? ❑ Yes ❑ No Are you routinely exposed to "Second Hand Smoke"? ❑Yes ❑No
Do you currently or have you ever used illegal or illicit drugs ❑Yes ❑No --- if Yes What? _____
Are you Sexually Active? ❑Yes ❑No Do you have protected sex? ❑ Yes ❑ No
Do you have any Religious or Cultural Customs that the physician should be aware of? ❑Yes_____ ❑No
Do you have an Advanced Directive or Living Will: ❑Yes ❑ No

Have you had a **COLONOSCOPY**? ❑Yes ❑ No Performed by: _____ Date: _____

Surgical History: Please list any surgery that you have had as well as date if possible

Surgical Procedure	**Date**	**Performed By**

GYN History: Women Only
Any Chance of Current Pregnancy? ❑Yes ❑ No Date of Last Period? _____ Age of first period? _____
Are you using Oral Contraceptives? ❑Yes ❑No Date of Last Pap? _____ Date of Last Mammogram? _____
Date of Last Bone Density Study? _____ Are you Post-Menopausal? ❑Yes ❑No

OB History:
Total Number of Pregnancies? _____ Full Term_____ Premature_____ Abortions Induced_____
Abortions Spontaneous_____ Ectopic _____ Multiple _____ Living _____

Morse Fall Scale:
Do you have a history of falling? ❑Yes ❑No
Do you have difficulty ambulating? ❑Yes ❑No
Do you use an Ambulatory Aid for walking? ❑None ❑Bed Rest ❑Nurse Assistant ❑Crutches ❑Cane ❑Walker ❑Furniture

Mental Health Screening:
Do you have little interest or pleasure in doing things? ❑Not at all ❑Several Days ❑More than half of the days ❑Nearly every day
Feeling down, depressed, or hopeless? ❑Not at all ❑Several Days ❑More than half of the days ❑Nearly every day

PAST MEDICAL History:

❑ Y	❑ N	Abdominal Pain	❑ Y	❑ N	Diabetes or High Blood Pressure	❑ Y	❑ N	Liver Disease
❑ Y	❑ N	ADD/ADHD	❑ Y	❑ N	Difficult Urination	❑ Y	❑ N	Lung Disease
❑ Y	❑ N	Allergic Rhinitis	❑ Y	❑ N	Diverticulitis	❑ Y	❑ N	Lyme Disease
❑ Y	❑ N	Amputations	❑ Y	❑ N	Dizziness/Fainting Spells	❑ Y	❑ N	Lymphoma
❑ Y	❑ N	Anemia or Blood Disorder	❑ Y	❑ N	Ear or Hearing Problems	❑ Y	❑ N	Malabsorption
❑ Y	❑ N	Anesthesia Complications	❑ Y	❑ N	Emphysema	❑ Y	❑ N	Multiple Sclerosis
❑ Y	❑ N	Anxiety Disorder	❑ Y	❑ N	Enlarged Prostate	❑ Y	❑ N	Neck Pain/Injury
❑ Y	❑ N	Asbestosis	❑ Y	❑ N	Erectile Dysfunction	❑ Y	❑ N	Neurological Conditions
❑ Y	❑ N	Asthma	❑ Y	❑ N	Excessive Cough or Blood Sputum	❑ Y	❑ N	Neuropathy
❑ Y	❑ N	Atrial Fibrillation/Arrhythmia	❑ Y	❑ N	Fibroid Uterus	❑ Y	❑ N	Obesity
❑ Y	❑ N	Bladder Incontinence	❑ Y	❑ N	Fibromyalgia	❑ Y	❑ N	Obstructive Sleep Apnea
❑ Y	❑ N	Bladder Problems	❑ Y	❑ N	Fractures	❑ Y	❑ N	Osteoporosis
❑ Y	❑ N	Blood Clot Disorder	❑ Y	❑ N	GERD/Reflex	❑ Y	❑ N	Parkinsons Disease
❑ Y	❑ N	Blood in Urine	❑ Y	❑ N	Gout	❑ Y	❑ N	Peripheral Vascular Disease
❑ Y	❑ N	Bowel Incontinence	❑ Y	❑ N	Head Trauma Concussion	❑ Y	❑ N	Pheochromocytoma
❑ Y	❑ N	Bowel or Bladder Incontinence	❑ Y	❑ N	Headaches or Migraines	❑ Y	❑ N	Pneumonia
❑ Y	❑ N	Bronchiectasis	❑ Y	❑ N	Heart Attack/MI	❑ Y	❑ N	Pulmonary Embolism
❑ Y	❑ N	Cancer	❑ Y	❑ N	Heart Conditions	❑ Y	❑ N	Rectal Bleeding
❑ Y	❑ N	Cataracts	❑ Y	❑ N	Heartburn/Bloating	❑ Y	❑ N	Schizophrenia
❑ Y	❑ N	Change in Eating Habits	❑ Y	❑ N	Hemorrhoids	❑ Y	❑ N	Seizures/Epilepsy
❑ Y	❑ N	Change in Stool	❑ Y	❑ N	Hepatitis	❑ Y	❑ N	Skin Disorder
❑ Y	❑ N	Chest Pain or Pressure	❑ Y	❑ N	Hernia	❑ Y	❑ N	Spina Bifida
❑ Y	❑ N	Cholesterol Evaluation	❑ Y	❑ N	Hypertension	❑ Y	❑ N	Stroke
❑ Y	❑ N	Colitis	❑ Y	❑ N	Hypogonadisim	❑ Y	❑ N	Swelling of Ankles/Legs
❑ Y	❑ N	Congestive Heart Failure	❑ Y	❑ N	Infectious Disease	❑ Y	❑ N	Thyroid Problems
❑ Y	❑ N	Constipation	❑ Y	❑ N	Interstitial Cystitis	❑ Y	❑ N	Tuberculosis
❑ Y	❑ N	COPD	❑ Y	❑ N	Irritable Bowel	❑ Y	❑ N	Varicose Veins
❑ Y	❑ N	Coronary Artery Disease	❑ Y	❑ N	Jaundice	❑ Y	❑ N	Vascular Disease
❑ Y	❑ N	Cushing's Disease	❑ Y	❑ N	Kidney Disease	❑ Y	❑ N	Vision or Eye Problems
❑ Y	❑ N	Deep Vein Thrombosis	❑ Y	❑ N	Kidney Stones	❑ Y	❑ N	Others Not Listed
❑ Y	❑ N	Degenerative Disc Disease	❑ Y	❑ N	Kidney or Bladder Problems			
❑ Y	❑ N	Depression	❑ Y	❑ N	Leukemia			

Name of Person Completing Form: _____

Signature: _____ Relationship to Patient: _____