Troy Andreasen, M.D., Inc.

3333 E. Concours St., Bldg. #3 Ontario, CA 91764
Ph: 909.291.4900 Fax: 909.291.4904

Patient Information Sheet

Name: _____ Today's Date:_____

Address: _____

City: _____ Zip Code: _____

Home Phone:_____ Mobile Phone: _____

Work Phone: _____ Occupation:_____

Social Security #: _____ Date of Birth: _____

Martial Status: S M D Sep Age: _____

Email address: _____

Emergency Contact: _____Phone #: _____

Spouse Name: _____Spouse Work #: _____

How did you hear about us?

_____

Reason for consultation:

_____

Time frame for surgery is:

_____

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Dear Patient,

The office of Dr.Troy Andreasen works diligently to respect the privacy of your personal information. Please take a moment to become familiar with what information we collect and how we protect and use that information. The following is the privacy policy for Troy Andreasen, M.D., Inc.

- Troy Andreasen, M.D., Inc. has trained its staff in the importance of maintaining patient confidentiality. Troy Andreasen, M.D., Inc. is responsible for enforcing these privacy rules.
- Troy Andreasen, M.D., Inc. only collects that information which is pertinent for providing quality care.
- Troy Andreasen, M.D., Inc. makes every effort to describe in plain English all aspects of your care. Your consent will be obtained for specific procedures performed by a named caregiver. In addition, you will be asked to consent to allow your personal records to be monitored by approved external reviewers. Occasionally, your case history may be included in a scientific study. Be assured, every effort will be taken to preserve you privacy.
- Troy Andreasen, M.D., Inc. will maintain physical, electronic, and procedural safeguards to protect personal information we obtain from you.
- Troy Andreasen, M.D., Inc. will only share personal information with other caregivers on a need-to-know basis.
- Troy Andreasen, M.D., Inc. will respect your expressed desire not to share certain information. You may so direct at any time.
- Troy Andreasen, M.D., Inc. will require other providers to whom we disclose your personal information to adhere to Troy Andreasen, M.D., Inc. policy.

If at any time you should feel that your privacy is being compromised, please let the Troy Andreasen, M.D., Inc. administrator know immediately.

Thank you for choosing Dr. Troy Andreasen.
Administrator, Troy Andreasen, M.D., Inc.

I have been provided this information and given an opportunity to ask questions. I have been asked if I would like a copy.

_____ _____
Patient/Legal Guardian Signature Date

_____
Witness

PRE-OPERATIVE HEALTH QUESTIONNAIRE

DATE_____ PATIENT NAME_____

AGE_____ SEX_____ HEIGHT_____ WEIGHT_____

ALLERGIES	YES	NO	DESCRIB
ARE YOU ALLERGIC TO ANY MEDICINE?	____	____	_____
DESCRIBE THE REACTION YOU HAVE:	_____		

MEDICINE	YES	NO	DESCRIBE
DO YOU TAKE PRESCRIPTION MEDICINE NOW?	____	____	_____
DOSE: _____			
DO YOU TAKE ANY NON-PRESCRIPTION MEDS REGULARLY?	____	____	_____

LIFESTYLE	YES	NO	DESCRIBE
DO YOU SMOKE CIGARETTES?	____	____	_____
IF YES, HOW MANY PER DAY? _____			
HOW LONG HAVE YOU SMOKED? _____			
DO YOU DRINK ALCOHOL?	____	____	_____
IF YES, HOW MANY DRINKS PER WEEK? _____			
HOW MANY DRINKS AT A TIME? _____			
DO YOU HAVE, OR HAVE YOU EVER HAD AN ALCOHOL DEPENDENCY?	____	____	_____
DO YOU USE STREET/RECREATION DRUGS?	____	____	_____
IF YES, HOW OFTEN? _____			
WHICH DRUGS DO YOU USE? _____			

GENERAL HEALTH

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (IF YES, DESCRIBE CURRENT TREATMENTS INCLUDING MEDICATIONS)

	YES	NO	DESCRIBE
• GASTROINTESTINAL			
ULCERS/GASTRITIS	____	____	_____
FREQUENT HEARTBURN/HIATAL HERNIA	____	____	_____
CIRRHOSIS	____	____	_____
HEPATITIS/YELLOW JAUNDICE	____	____	_____
OTHER LIVER PROBLEMS	____	____	_____
• HEART			
HIGH BLOOD PRESSURE	____	____	_____
CHEST PAIN	____	____	_____
HEART MURMUR	____	____	_____
ANGINA	____	____	_____
CONGESTIVE HEART FAILURE	____	____	_____
IRREGULAR HEART BEATS	____	____	_____
HEART ATTACK	____	____	_____
OTHER HEART PROBLEMS	____	____	_____
HAVE YOU EVER HAD TROUBLE WITH:			
RHEUMATIC FEVER	____	____	_____
MITRAL VALVE PROLAPSE	____	____	_____
HEART MURMUR	____	____	_____

- HEART (…continued) YES NO DESCRIBE
  - DIFFICULTY WALKING UP 2 FLIGHTS OF STAIRS ____ ____ _____
  - HAVING TO STOP TO CATCH YOUR BREATH ____ ____ _____
  - HAVE YOU BEEN ADVISED TO TAKE ANTIBIOTICS PRIOR TO DENTAL CARE? ____ ____ _____
- RESPIRATORY
  - HAVE YOU HAD A COLD, COUGH, OR FLU IN THE PAST 2 WEEKS? ____ ____ _____
  - ASTHMA ____ ____ _____
  - ANKLE SWELLING/EDEMA ____ ____ _____
  - FREQUENT BRONCHITIS ____ ____ _____
  - TUBERCULOSIS ____ ____ _____
  - EMPHYSEMA ____ ____ _____
  - SHORTNESS OF BREATH ____ ____ _____
  - OTHER LUNG PROBLEMS ____ ____ _____
- KIDNEY
  - KIDNEY FAILURE ____ ____ _____
  - KIDNEY STONES ____ ____ _____
  - OTHER KIDNEY PROBLEMS ____ ____ _____
- ENDOCRINE
  - OVERACTIVE THYROID ____ ____ _____
  - UNDERACTIVE THYROID ____ ____ _____
  - OTHER THYROID PROBLEMS ____ ____ _____

  IF YES, WHEN WAS YOUR LAST THRYOID FUNCTION BLOOD TEST? _____
  - DIABETES ____ ____ _____

  IF YES, HOW LONG HAVE YOU BEEN DIABETIC? _____
  - WHAT MEDICATION DO YOU TAKE? _____
- NEURO
  - STROKE ____ ____ _____
  - SEIZURES ____ ____ _____

  WHEN WAS YOUR 1ST SEIZURE? _____
  - HOW OFTEN DO YOU HAVE THEM? _____
  - WHEN WAS YOUR LAST SEIZURE? _____
  - WHAT MEDICATIONS DO YOU TAKE? _____
  - WHAT IS THE CAUSE OF YOUR SEIZURES? _____
- SURGERY
  - WHAT SURGERIES HAVE YOU HAD?

DATE OPERATION COMPLICATIONS

_____

_____

_____

HAS A BLOOD RELATIVE EVER HAD A REACTION TO ANESTHESIA? _____YES _____NO

FEMALES: LAST MENSTRUAL PERIOD _____

PATIENT SIGNATURE: _____ DATE: _____

- *HEALTH HISTORY REVIEWED AND UPDATED*

PATIENT SIGNATURE: _____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____