MIAMI VALLEY
PLASTIC SURGEONS

Frank V. Troha, M.D. • Thaddeus P. O'Neill, M.D. • Nichole Gill, PA-C
1520 S. Main Street • Suite 200 • Dayton, OH 45409
(937) 228-5115
www.miamivalleyplasticsurgeons.com

DATE _____ /_____ /_____

HEALTH QUESTIONNAIRE

Name _____ **Birthdate** _____ **Age** _____

Date of Last:

Colonoscopy **Month** _____ **Year** _____

Mammogram **Month** _____ **Year** _____

Flu Shot **Month** _____ **Year** _____

SURGERY (Previous)	DATE

✓ FAMILY HISTORY	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
_____						

- ❒ Blood Clot
- ❒ Defib / Pacemaker
- ❒ High Blood Pressure
- ❒ Heart Arrhythmia
- ❒ Heart Murmur
- ❒ Heart Attack
- ❒ High Cholesterol
- ❒ Peripheral Vascular Disease
- ❒ Allergies/Hay Fever
- ❒ Asthma
- ❒ Bronchitis
- ❒ Pneumonia
- ❒ Ulcer
- ❒ GI Disorder
- ❒ Gall Bladder Disease
- ❒ Prostate Disease
- ❒ Incontinence
- ❒ Sexually Transmitted Disease
- ❒ Hepatitis Type_____Year_____
- ❒ Anemia
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Gout
- ❒ Anxiety
- ❒ Depression
- ❒ Thyroid Disease
- ❒ Diabetes Type I ❒ Type II ❒
- ❒ Last A1C blood test _____
- ❒ Chronic Rashes
- ❒ Cancer _____type
- ❒ Skin Cancer
- ❒ HIV
- ❒ Tuberculosis
- ❒ Other Diseases _____

SOCIAL HISTORY

❒ **Tobacco Use: Packs daily** _____ *Type?* *How long?* *When stopped?*

❒ **Illicit Drug Use:** _____

❒ **Alcohol: Frequency** _____

Patient Signature _____

OVER

DATE _____ /_____ /_____

MEDICATION LIST

Name _____ Birthdate _____ Age _____

PRESCRIPTION MEDICATIONS	PURPOSE OR REASON TAKEN	DOSE	FREQUENCY	FORM (LIQUID, CAPSULE, TABLET, INJECTION)	CURRENT DATE

OVER-THE-COUNTER MEDICATIONS	PURPOSE OR REASON TAKEN	DOSE	FREQUENCY	FORM (LIQUID, CAPSULE, TABLET, INJECTION)	CURRENT DATE

Drug Allergies _____ NKDA _____

Local Pharmacy _____ Pharmacy Phone _____

Cardiologist _____ Phone _____

Blood Thinners ➜ ❒ No ❒ Yes ➜ Name _____

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DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ / _____ / _____ SEX: ☐ MALE ☐ FEMALE ☐ SSN: _____ MARITAL STATUS: _____

(Please check the box to indicate your preferred phone number)

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____ EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

LANGUAGE: _____ ☐ INTERPRETER NEEDED: _____

SPOUSE'S NAME: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME: _____

POLICY HOLDER: _____ POLICY HOLDER SSN: _____

POLICY HOLDER DATE OF BIRTH: _____ PATIENT RELATIONSHIP TO INSURED: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

OTHER INSURANCE PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **MIAMI VALLEY PLASTIC SURGEONS, INC.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____