Dr. James S. Kohn MD, FACS

General and Vascular Surgery

Date _____

Patient Information (Please Print)

Full Name: _____ Age: _____ DOB: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____ SSN: _____

Employers Address: _____ How Long Employed: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: _____ DOB: _____ SSN: _____

Reason for Visit:

_____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship To Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Health Insurance Information:

Primary Insurance: _____ Policy Holder: _____

Secondary Insurance: _____ Policy Holder: _____

Person Responsible for Account: _____ Phone: _____

All professional services are charged to the patient and necessary insurance forms will be completed on their behalf and filed with the insurance carrier. The patient is responsible for all fees (co-pays, deductibles, etc). I hereby authorize payment to James S. Kohn, M.D. for Surgical and Medical benefits. I understand that I am financially responsible for all charges whether or not covered by Insurance.

Patient Signature: _____ Date: _____

Dr. James S. Kohn MD, FACS

Patient History

NAME: **DATE:**

How did you find out about Dr. Kohn? _____

Did a physician refer you? ☐ Yes ☐ No If Yes, please note the physicians name: _____

Who is your Primary Care Physician? _____ Date of last visit: _____

History of Present Illness

Weight: _____ Height: _____

Reason for today's visit: _____

_____

_____

Past Medical History

(Circle conditions that apply)

Diabetes	Insulin: Yes No	Stroke	When: _____
Heart Disease	History of Heart Attack Blockage of Arteries Heart Failure	Arthritis	Osteo/ Rheumatoid/ Gout
		Psychiatric	Depression/ Anxiety/ Other
High Blood Pressure		Other: _____	
Lung Disease	Emphysema/ Asthma/ Bronchitis	_____	
Kidney Disease			

Past Surgical History

Have you ever had any bleeding problems? Yes No Please list all Operations and Dates:

Are you taking any blood thinners? Yes No
Aspirin/ Plavix/ Coumadin

_____
_____
_____
_____
_____

Medications and Dosage

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any Allergies and Your Reaction: _____

_____

Family History (first degree relatives)

Heart Disease	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____
Cancer	Yes	No	Who? _____

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Patient History (Continued)

Social History

Who do you live with? _____ Do you drive? Yes No

What type of work do/ did you do? _____ Retired? _____ When? _____

Have you ever smoked? Yes No How many years? _____ How many average packs per day? ____
Quit? Yes No When? _____

Do you use alcohol? Yes No Type _____ How much? _____ How Often? _____

Have you ever used recreational or intravenous drugs? Yes No Type: _____

HIV Status + - Hepatitis A B C (circle all that apply)

Review of Systems

(Circle those that apply)

Constitutional	Fever or Chills, Weight Loss or Gain, Poor appetite	Skin	New Rashes, New Moles or Warts, Thickened or Brittle Nails
		(women)	Date of Last Mammogram:
Cardiovascular	Chest Pain, Palpitations, Leg Pain at Night or with Exercise, Impotence, Color Changes or Cold Feet	Neurological	Numbness or Tingling Spinal Injury: Date: _____ Level: _____
Respiratory	Shortness of Breath, Cough, Use of Oxygen, Date of Last Chest X-ray: _____		Spasms
		Psychiatric	Depression, Anxiety, Alzheimer's or Dementia, Poor Memory
Gastrointestinal	Constipation, Diarrhea, Change in Stool Shape, Blood in or Black Stool, Reflux, Heart Burn	Eyes	Wear Glasses Cataract R L Both Blind R L Both
Genitourunary	Incontinence, Frequent Urination, Difficulty starting Urination, Pain with Urination	ENT	Poor Hearing R L Both Dentures Trouble Swallowing
Gynecologics	Heavy Periods, Irregular Periods or Spotting Date of Last Period: _____ Date of Last Pap Smear: _____	Hematologic	History of Blood Transfusion, Easy Bruising, Bleeding Problems
Musculoskeletal	Pain in Joints? Where? _____ _____ Leg Swelling R L Back Pain Weakness		

Do you walk Independently
With Assistance
With a Walker or Cane

Do you use a wheelchair? Yes No
Special Cushion Yes No
Type: _____

Completed By: _____

Patient or Patient's Representative Date

Reviewed & Updated By: _____

Physician Signature Date