Huntsville Vascular Specialists, P.C. **Gary M. Gross, MD, FACS**
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Huntsville, AL 35801 Fax: (256) 883-8230

MEDICAL QUESTIONAIRE

Date: ____/____/____

Name: _____ Birth Date: ____/____/____ Age: ____ Sex: Male / Female

SSN: _____-____-_____ Driver's License #: _____ Occupation: _____ Retired Y / N

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____-_____-_____ Cell #: _____-_____-_____ Work #: _____-_____-_____

Primary Insurance: _____ Contract #: _____ Group #: _____

Name of Card Holder: _____ Birth Date of Card Holder: _____/_____/_____

Second Insurance: _____ Contract #: _____ Group #: _____

Name of Card Holder: _____ Birth Date of Card Holder: _____/_____/_____

Spouse's Name: _____ Birth Date: _____/____/_____ SSN: _____-_____-_____

I will be responsible for payments for all services rendered to me by Gary M. Gross, MD. This includes collection, attorney fees, and court costs if needed. I authorize Dr. Gross to release any information necessary to process my insurance claims. I authorize payment of medical benefits to Gary M Gross, MD for services rendered

Signature: _____ Date: _____

Name of physician requested consultation: _____

Name of family physician: _____

Other physicians seen in the last two years: _____

******List any allergies to medications: _____

Describe the medical problem/symptoms that brought you here today: _____

_____

Do you or did you smoke cigarettes? Yes / No *If you quit, what year? _____
How many packs per day & for how many years? _____
How much alcohol do you drink per week? _____
Have you consumed more alcohol in the past? How much? _____

PAST MEDICAL ILLNESSES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

HOSPITAL ADMISSIONS (non-surgical)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PAST SURGERIES (Surgery, Date, Complications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICATIONS

NAME	DOSAGE	HOW OFTEN TAKEN	COMMENT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

How far can you walk before pain starts? _____

Do you have pain while resting? _____ Sores on feet or legs? _____

Please circle and add any comments to the following conditions that apply to you.

Head / Neuro: Fainting spells Headaches Seizures Epilepsy Neuropathy Stroke TIA_____

Eyes: Blurred vision Cataracts Glaucoma Blindness _____

Ears, Nose & Throat: Allergies Sinus Loss of hearing_____

Heart: Heart murmur Arrhythmia Heart attack Congestive heart failure Coronary artery disease Angina

Chest pain Pacemaker implant High blood pressure_____

Lungs: Emphysema Bronchitis Tuberculosis Persistent cough Productive cough Shortness of breath_____

Endocrine System: Thyroid problems Diabetes High cholesterol Lipid problems_____

Blood & Liver: Hepatitis Jaundice HIV / AIDS Anemia Bleeding disorder_____

Digestive System: Hiatal Hernia Stomach ulcers Polyps Reflux Diarrhea Constipation Blood in bowel movements_____

Musculoskeletal: Arthritis Painful or swollen joints Bone pain Muscle weakness _____

Reproductive System: Enlarged prostate Fibroid tumors STD's Breast lumps_____

Kidneys / Bladder: Renal failure Stones Infections Bleeding_____

Skin: Cancer Moles that have changed Discoloration_____

Veins: Phlebitis Blood clots (legs / lungs) Leg pain Bulging ropy vein_____

Please list any other health conditions not covered

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FAMILY HISTORY

Medical Problems / Cause of Death

Mother: Living / Deceased **(circle one)**

_____

Medical Problems / Cause of Death

Father: Living / Deceased **(circle one)**

_____

Sisters: How many living? How many deceased?

Brothers: How many living? How many deceased?

If not stated above,* ***please circle* *any conditions present in mother, father, brother, sister, aunts, uncles or grandparents**

ANEURYSM CANCER HEART ATTACK STROKE VARICOSE VEINS

HIGH BLOOD PRESSURE HIV/AIDS TUBERCULOSIS DIABETES

PERSONAL HISTORY

Are you: (circle one) Married Single Divorced Widow(er)

If other than single, how long? _____ How many children? _____

Where were you born? _____ How long have you lived here? _____

Employer Name & Phone: _____

What is / was your occupation? _____

CONTACT INFORMATION

PHARMACY: _____ PHONE #: _____

LOCATION: _____

I AUTHORIZE THIS OFFICE TO DISCLOSE MY MEDICAL INFORMATION (per HIPPA) TO THE FOLLOWING FAMILY MEMBERS / EMERGENCY CONTACTS:

NAME: _____ PHONE #: _____

Relationship to patient: _____

NAME: _____ PHONE #: _____

Relationship to patient: _____

Please list any additional information relevant to what brought you here today: