Paragon Surgical Specialists Date: _____

Name: _____ Birth Date: _____

Reason for Today's Visit: _____

Height _____ Weight _____ Local Pharmacy:_____

Primary Care Physician:_____ Referring Physician:_____

Please Complete Any Changes Below *(if applicable)*: No Change _____

Medication Changes Since Last Visit: *Yes or No* Changes: _____

Allergy Changes Since Last Visit: *Yes or No* Changes: _____

Other Allergy Changes Since Last Visit:

☐ Adhesive Tape ☐ Latex ☐ Shellfish ☐ Betadine ☐ Others_____

Most Recent Mammogram: _____(year) or Never Most Recent Colonoscopy: _____(year) or Never

Email Address:_____ Phone Number:_____

Social History:

Tobacco Use: Yes No Previous *If Yes, Type & Amount?* _____

Drug Use: Yes No Previous *If Yes, Amount?* _____

Alcohol Use: Yes No Previous *If Yes, Amount?* _____

Request for Treatment: Paragon Surgical Specialists maintains personnel and facilities to assist my physicians in providing me medical care and I authorize this staff to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available methods of alternative treatment, together with an explanation of the risks associated with each of them. I also have the right to ask questions regarding my care and have the answered to the best of my physician's ability. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice.

Signature:_____ **Date:** _____

Staff Use: BP:____ HR:____ T:____

Fall Risk Assessment: ≥65 yrs. Yes No

Ambulatory Yes No Screening Not Done for Medical Reason Yes No

In the past yr. pt. has had: ____ ≥2 falls (1100F) ____ 1 fall w/ injury (1100F) ____ No falls (1101F)

Get-up & Go Score (1-5)____ Functioning well with vision Yes No (3288F)