JASON H. FROST, D.O., F.A.C.O.S., P.A.
New Patient Consultation

Patient Name: _____ Nick Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Weight: _____ Sex: ☐M ☐F Marital Status: ☐M ☐S ☐D ☐W
Name of Insurance: _____ Occupation: _____
Primary Physician's Name: _____ Dr.'s Phone Number: _____
Referral Source (if other than Primary Physician): _____

Please check if you currently have or have had in the past any of the following medical conditions:

☐Breast Cancer ☐Colon Cancer ☐Lung Cancer ☐Prostate Cancer ☐Ulcer Disease
☐Thyroid Disease ☐Glaucoma ☐G.E.R.D. ☐Diabetes ☐HIV
☐Heart Attack ☐Stroke ☐High Blood Pressure ☐Seizures ☐Congen.Heart Failure
☐Atrial Fibrillation ☐Endometriosis ☐Arthritis ☐High Cholesterol ☐COPD/Emphysema
☐Mitral Valve Prolapse ☐Asthma If yes, when was your last attack? _____
☐Anemia Now? ____ In the past? ____ ☐Bleeding problems or tendencies to bleed
☐Hepatitis A ___ B ___ C___ ☐ Diverticulitis ☐Diverticulosis ☐ Depression
☐Anxiety ☐Other: _____ ☐Denies All / None

Please check **ALL** surgical procedures that apply to you:

☐Gallbladder ☐Hernia ☐Tonsils ☐Breast Surgery (Biopsy? - Lumpectomy? - Excision?) ☐Lap Tubal-ligation
☐Hysterectomy ☐ Ovaries ☐Thyroid ☐Colonoscopy ☐Endoscopy ☐Laparoscopy ☐Appendectomy
☐Pacemaker ☐Back Surgery ☐C-Section x ____ ☐Colon Surgery ☐Plastic surgery Type: _____
☐Cancer Type: _____ ☐ Open Heart ☐ Cataract ☐ Orthopedic: _____
Other: _____ ☐None

Do you take any medications? Yes or No Diet Medications? Yes or No
If yes, please list all medication names: _____
_____

Do you take any Motrin or Aspirin products? Yes or No Daily? _____ As needed? _____
FEMALES - Do you do self breast examinations? Yes or No How often? _____
Are you **ALLERGIC** to any foods or medications? Yes or No
If yes, please list names and describe the reaction you had: _____
_____

Do you or have you in the past smoked cigarettes? Yes or No Never
If yes, how many per day? _____ cigarettes or pack / s For how long? _____ Quit? When? _____

Do you drink alcohol? Yes or No Daily? _____ Socially? _____

Family History of: ☐Breast Cancer ☐Colon Cancer ☐Gallbladder Disease ☐Heart Attack ☐Diabetes Mellitus
If any of the above apply, please list relation and age of onset: _____

Review of Systems: _____

PLEASE DO NOT WRITE BELOW THIS LINE, IT IS FOR DR. USE ONLY

_____
_____
_____