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? _____

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

_____

_____

_____