

Dear Patient,

Thank you for choosing Windham Surgical Group. We are conveniently located at **162 Mansfield Avenue, Willimantic, CT**, near Windham Community Memorial Hospital.

In order to be seen in a timely fashion, you must provide the following items when you arrive for your appointment.

1. **A list of all your medications including the strength and dosage**
2. **A Drivers License / Non-Driver's License. Other picture ID only if you do not have a license.**
3. **Insurance Cards**
4. **Insurance Co-Pay (required at time of service)**
5. **Insurance Referral (if applicable)**
6. **Workers' Compensation Information (if applicable)**
7. **If do not have Insurance, please contact our office prior to your appointment so that we can work with you to set up a payment arrangement (860-423-4999).**

If this is a Workers' Compensation claim, please contact our office prior to your appointment and speak to the Billing Department (860-423-4999) to be sure that all of the paperwork is completed in a timely fashion.

If your insurance requires you to have a referral for you to be seen by a specialist, please be sure the referral is in place prior to your appointment. Your primary care physician will need to complete this for you. A phone call from your physician is not considered a referral.

Please be sure you arrive at the time indicated above. If you are required to complete paperwork prior to your appointment, time has already been allowed for you to do so. You do not need to arrive earlier than the time indicated above for your appointment.

If you have any questions, or if we can be of further assistance, please contact the Billing Department at 860-423-4999.

Sincerely,
Windham Surgical Group

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Past Medical History

Have you ever had:

- | | |
|---|---------------------------|
| Hypercholesterolemia (High Cholesterol) | <input type="radio"/> Yes |
| Hypertension (high blood pressure) | <input type="radio"/> Yes |
| Atrial fibrillation (Rapid Heart Rate) | <input type="radio"/> Yes |
| Mitral valve prolapse | <input type="radio"/> Yes |
| Heart disease | <input type="radio"/> Yes |
| Heart Attack | <input type="radio"/> Yes |
| DVT (Deep Vein Thrombosis) | <input type="radio"/> Yes |
| Stroke | <input type="radio"/> Yes |
| Phlebitis (Inflammation of the Veins) | <input type="radio"/> Yes |
| GERD (Acid Reflux / Heartburn) | <input type="radio"/> Yes |
| Irritable Bowel Syndrome | <input type="radio"/> Yes |
| Diverticulitis | <input type="radio"/> Yes |
| Migraines | <input type="radio"/> Yes |
| Seizures | <input type="radio"/> Yes |
| Diabetes | <input type="radio"/> Yes |
| Asthma | <input type="radio"/> Yes |
| Tuberculosis | <input type="radio"/> Yes |
| Depression | <input type="radio"/> Yes |
| Hepatitis | <input type="radio"/> Yes |
| Prostate Disorders | <input type="radio"/> Yes |
| Cancer, Prostate | <input type="radio"/> Yes |
| Lymphoma | <input type="radio"/> Yes |
| Leukemia | <input type="radio"/> Yes |
| Cancer, Colon | <input type="radio"/> Yes |
| Thyroid Problems | <input type="radio"/> Yes |
| COPD (Chronic Obstructive Pulmonary Disease) | <input type="radio"/> Yes |
| Cancer, Thyroid | <input type="radio"/> Yes |
| Breast cancer | <input type="radio"/> Yes |
| Malignant Hyperthermia (Serious Anesthesia Complications) | <input type="radio"/> Yes |

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Past Surgical History

Have **you had** any of the following operations?

- Appendectomy
- Removal of Gallbladder
- Caesarean Section
- Hysterectomy
- Colon Operations
- Colonoscopy
- Heart Surgery
- Heart Stent
- Orthopedic Surgery
- Weight Reduction Surgery
- Other Operations:

Family History

Have **any of your immediate family members** had:

- Heart Disease Yes
- Other Cancers Yes
- Stroke Yes
- Diabetes Yes
- Colon Cancer Yes
- Colon Polyps Yes
- Breast Cancer Yes
- Lymphoma Yes
- Pancreatic Cancer Yes
- Prostate Cancer Yes
- Melanoma Yes
- Malignant Hyperthermia (Serious Anesthesia Complications) Yes

Social History

- Alcohol Yes
 No
 Daily
 Occasionally
 Rarely
- Smoking Yes
 No
 One Pack a day
 Two Packs a day
 Quit

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Please fill in the “Bubbles” completely with a pencil. If you are unsure of any of the answers, please do not fill in the “Bubble”. The Nurse and Physician will be reviewing this form with you.

Have you recently had:

- | | | |
|------------------------------|---------------------------|--------------------------|
| Weight gain | <input type="radio"/> Yes | <input type="radio"/> No |
| Weight loss | <input type="radio"/> Yes | <input type="radio"/> No |
| Black Stools | <input type="radio"/> Yes | <input type="radio"/> No |
| Rectal bleeding | <input type="radio"/> Yes | <input type="radio"/> No |
| Easy bruising of the skin | <input type="radio"/> Yes | <input type="radio"/> No |
| Bleeding problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Edema | <input type="radio"/> Yes | <input type="radio"/> No |
| Difficulty urinating | <input type="radio"/> Yes | <input type="radio"/> No |
| Loss of appetite | <input type="radio"/> Yes | <input type="radio"/> No |
| Diarrhea | <input type="radio"/> Yes | <input type="radio"/> No |
| Vomiting | <input type="radio"/> Yes | <input type="radio"/> No |
| Difficulty swallowing | <input type="radio"/> Yes | <input type="radio"/> No |
| Constipation | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in bowel habits | <input type="radio"/> Yes | <input type="radio"/> No |
| Heartburn | <input type="radio"/> Yes | <input type="radio"/> No |
| Fever | <input type="radio"/> Yes | <input type="radio"/> No |
| Dizziness | <input type="radio"/> Yes | <input type="radio"/> No |
| Cough | <input type="radio"/> Yes | <input type="radio"/> No |
| Shortness of breath | <input type="radio"/> Yes | <input type="radio"/> No |
| Palpitations | <input type="radio"/> Yes | <input type="radio"/> No |
| Chest pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Leg cramps | <input type="radio"/> Yes | <input type="radio"/> No |
| Seizures | <input type="radio"/> Yes | <input type="radio"/> No |
| Non-Healing wounds or ulcers | <input type="radio"/> Yes | <input type="radio"/> No |
| Suspicious skin changes | <input type="radio"/> Yes | <input type="radio"/> No |