Advanced Surgery

GLENN L. SANDLER, M.D. • CRAIG P. COLLIVER, M.D.

Dear Patient:

Your appointment is scheduled for ____.

____ Rockville Office: 9707 Medical Center Drive, Suite 320 Rockville, MD 20850

** **Please plan to arrive 20 minutes prior to your scheduled appointment time.**

We request updated forms be completed when your information has changed or once a year.

Please be sure to bring all items that apply:

- ✓ Completed Forms that are enclosed
- ✓ Diagnostic Imaging and/or Procedure Reports WITH corresponding written reports(s), if any. Ex. Mammo/US, Colonoscopy/EGD Procedure Reports w/ Color Photos. **(You will need to pick up these items from the facility where you had them performed.)**
- ✓ Lab results, if any. **(You will need to obtain a copy of the results from the physician who ordered them.)**
- ✓ Insurance Card(s)
- ✓ Current Drivers License or Photo ID
- ✓ Referral from your Primary Care Physician **(If required-you may need to call your insurance company if you are unsure.)**
- ✓ Method of payment: cash, check, Visa, MasterCard, Discover **(If your insurance plan requires a co-payment.)**

Please note a $25 charge will be applied for ALL missed appointments and/or appointments cancelled without a 24 hour business day prior notice.

If you have any questions please contact our office at 301.251.4128 Monday-Friday from 8:30am-4:30pm.

Sincerely,

Advanced Surgery, PC

9707 MEDICAL CENTER DRIVE, SUITE 320 * ROCKVILLE, MD * 20850

PHONE: (301) 251-4128 FAX: (301) 73 8-1593

www.advancedsurgery.net

ADVANCED SURGERY, PC

GLENN SANDLER MD AND CRAIG COLLIVER MD

Today's Date: (Please Print) For office Use: GS ☐ CC ☐

PATIENT INFORMATION

Primary Care Physician or Group:	Referring Physician:

First Name: **MI:** **Last Name:** **Preferred Name:**

☐ **Mr.** ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** ☐ **Sr.** ☐ **Jr.** ☐ **III**

Street address:	**City:**	**County:**
Street address 2:	**State:**	**ZIP Code:**

Home no.: ( )	**Cell no: ( )**	**Birth date:** **Age:**
Work no.: ( )	**Email: @**	**Social Security #:**

Sex: ☐ **M** ☐ **F** **Marital Status:** **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Partnered** ☐

Race: ☐ **Black** ☐ **Chinese** ☐ **Filipino** ☐ **Hispanic** ☐ **Indian** ☐ **Native American** ☐ **Native Hawaiian** ☐ **Other** ☐ **Asian** ☐ **Pacific Islander** ☐ **Caucasian**

Occupation:	**Employer:**	**Status: FT** ☐ **PT** ☐ **Ret** ☐ **Tmp** ☐ **Other:** ☐

Employer Address:	**City:**	**County:**
Employer Address 2:	**State:**	**ZIP Code:**

INSURANCE INFORMATION (Please give your insurance cards to the receptionist.)

Is this visit related to a work injury (Workman's Compensation)	☐ YES ☐ NO	☐ HMO ☐ PPO ☐ POS ☐ Open Access

Primary Insurance Name		**Telephone #:**

Street address: **City:** **State:** **ZIP:**

Subscriber's name: (If different from above)	**Subscriber's S.S. no.:**	**Birth date**:	**Policy no.**:	**Group no.:**

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	**Sex:** ☐ **M** ☐ **F**

Subscribers Place of Employment:		Tel Number:

Secondary Insurance Information

Secondary Insurance Name **Telephone #:** ☐ HMO ☐ PPO ☐ POS ☐ Open Access

Street address: **City:** **State:** **ZIP:**

Subscriber's name: (If different from above)	Subscriber's S.S. no.:	Birth date:	Policy no.:	Group no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	**Sex:** ☐ **M** ☐ **F**

Subscribers Place of Employment:		Tel Number:

WHO ARE WE AUTHORIZED TO COMMUNICATE WITH ON YOUR BEHALF?

I authorize verbal release of personal health information relevant to my care, such as test results, appointment information, etc. to the following individuals:	**Relationship to patient:**	**Cell phone no.:**	**Work/Home**

☐ YES ☐ DO NOT Leave a message on my answering machine/voice mail/email or with anyone in my household who answers the phone.

Advanced Surgery, PC
Dr. Glenn Sandler and Dr. Craig Colliver

HEALTH HISTORY QUESTIONNAIRE

Date:___________________________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical records

Name: (Last, First, M.I.) ☐ **M** ☐ **F** **DOB:** **Age:**

Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Primary Care Physicians: **Referring Physicians:**

PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY

PLEASE LIST YOUR MEDICATIONS AND DOSAGES (Please attach additional sheet if necessary)

Medication Name	Strength (MG)	Times per day	Referring Physician

ALLERGIES TO MEDICATIONS ☐ None

Name of Drug	Reaction You Had

Are you allergic or sensitive to LATEX? ☐ **Yes** ☐ **No**

PAST MEDICAL HISTORY (Please check all that apply)

☐ None	☐ Colitis	☐ Heart murmur	☐ MI/Heart attack	☐ Rheumatoid arthritis
☐ ADD	☐ Colon cancer	☐ Hepatitis A	☐ Migraine	☐ Seizure disorder
☐ Alzheimer's/Dementia	☐ Congestive Heart Failure	☐ Hepatitis B	☐ Mitral valve prolapse	☐ Sleep apnea
☐ Anemia	☐ COPD	☐ Hepatitis C	☐ Multiple sclerosis	☐ Stomach cancer
☐ Angina	☐ Coronary Artery Disease	☐ Herpes	☐ Osteoarthritis	☐ Stomach ulcer
☐ Anxiety	☐ Crohn's disease	☐ Hiatal hernia	☐ Osteoporosis	☐ SVT
☐ Aortic aneurysm	☐ CVA/Stroke	☐ High blood pressure	☐ Ovarian cancer	☐ Thyroid cancer
☐ Arthritis	☐ Depression	☐ High cholesterol	☐ Ovarian cysts	☐ Urinary infection-chronic
☐ Asthma	☐ Diabetes Type 1	☐ HIV/Aids	☐ Parkinson's disease	☐ Ulcerative colitis
☐ Atrial fibrillation	☐ Diabetes Type 2	☐ Hyperthyroidism	☐ **Presently pregnant**	☐ Urinary incontinence
☐ Blood clotting issues	☐ Diverticulitis	☐ Hypothyroidism	☐ Prostate cancer	☐ **Use Coumadin**
☐ Bowel obstruction	☐ Endometriosis	☐ Irritable bowel syndrome	☐ Prostate enlarged	☐ **Use Plavix**
☐ Breast cancer	☐ Fibromyalgia	☐ Kidney stones	☐ Poor circulation	☐ **Use aspirin**
☐ Cervical cancer	☐ GI Bleed	☐ Low platelets	☐ Pulmonary embolism	☐ **Use other anticoagulant**
☐ Cirrhosis	☐ H. pylori	☐ Lupus	☐ Reaction to anesthesia	☐ Other__________________
☐ Clots in legs	☐ Heartburn/Reflux	☐ Melanoma	☐ Renal failure chronic	

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Health History Questionnaire

(Continued)

Name: ____ Date:__________________________________

PAST SURGICAL HISTORY (Please check all that apply)

☐ None	☐ Cataract extraction	☐ Kidney removed	☐ Sinus surgery
☐ Abdominal surgery exploratory	☐ Colon resection	☐ Knee arthroscopy	☐ Small bowel resection
☐ Abdominoplasty/tummy tuck	☐ Colonoscopy	☐ Knee replacement	☐ Splenectomy
☐ Angioplasty/stent	☐ Dental surgery	☐ Lumpectomy	☐ Stomach(part of removed)
☐ Aortic valve replacement	☐ Ectopic pregnancy	☐ Lung resection	☐ Thyroidectomy
☐ Appendectomy	☐ Femoral hernia	☐ Mastectomy	☐ Tonsillectomy
☐ Axillary lymph node dissection	☐ Gallbladder removed	☐ Mitral valve replacement	☐ Tooth extraction
☐ Back surgery	☐ Gastric bypass	☐ Ovarian cyst removal	☐ Tubal ligation
☐ Bladder surgery	☐ Hand/Finger surgery	☐ Pacemaker	☐ TURBT
☐ Brain surgery	☐ Heart bypass	☐ Pancreatic surgery	☐ TUR
☐ Breast biopsy	☐ Hemorrhoidectomy	☐ Pilonidal cyst	☐ Umbilical hernia
☐ Breast implants	☐ Hip replacement	☐ Prostate removal	☐ UPPP
☐ Breast reduction	☐ Hysterectomy w/tubes & ovaries	☐ Remove tubes/ovaries only	☐ Valve replacement
☐ C section	☐ Hysterectomy w/o tubes & ovaries	☐ Rotator cuff repair	☐ Vasectomy
☐ Carotid endarterectomy	☐ Incisional hernia	☐ Sentinel lymph node biopsy	☐ Other
☐ Carpal tunnel	☐ Inguinal hernia	☐ Shoulder surgery	__________________

Family History of (Please select all that apply)

☐ None ☐ Unknown

Please indicate, next to the condition, the family member who has or had the disease using the abbreviations below:

M=Mother, F=Father, S-Sister, B=Brother, MGF=Maternal Grandfather, PGF=Paternal Grandfather, MGM=Maternal Grandmother PGM=Paternal Grandmother, PU=Paternal Uncle, MU=Maternal Uncle, PA=Paternal Aunt, MA=Maternal Aunt

☐ Bladder cancer ________	☐ Melanoma ________
☐ Breast cancer ________	☐ Ovarian cancer ________
☐ Colon cancer ________	☐ Pancreatic cancer ________
☐ Crohn's disease ________	☐ Prostate cancer ________
☐ Gastric cancer ________	☐ Reaction to anesthesia ________
☐ Head and Neck cancer ________	☐ Stomach cancer ________
☐ Kidney cancer ________	☐ Thyroid cancer ________
☐ Liver cancer ________	☐ Ulcerative colitis ________
☐ Lung cancer ________	☐ Uterine cancer ________
☐ Lymphoma ________	☐ Other ____

Social History (Please check each column)

Marital Status:	Employment status:	Tobacco (choose one)	Do you drink alcohol?
☐ Single	☐ Employed	☐ Current every day smoker	☐ Yes ☐ No
☐ Married	☐ Not employed	☐ Current some day smoker	If yes, what kind?
☐ Divorced	☐ Self employed	☐ Cigarettes Amount___ pks/day	______________________
☐ Separated	☐ Stay at home mom	☐ Cigars Amount___ #/week	# drinks per day? ________
☐ Widowed	☐ Retired	☐ Chew Amount___ #/day	
☐ Partnered	☐ Student	☐ Former smoker: Year quit ______	
		☐ Never smoker	

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Health History Questionnaire

(Continued)

Name: ______________________________ Date: ______________________________

Height and Weight

Height: ____________________ Weight: ________________

Please check off all that apply for each body system

General complaints of:

- ☐ No Complaints of this type
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Lack of Appetite
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Unable to sleep
- ☐ Weakness

Skin

- ☐ No Complaints of this type
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Yellowing Skin
- ☐ Changes in Hair
- ☐ Changes in Nails
- ☐ Changes in Moles/Lesions
- ☐ New Skin Lesions

Nervous System

- ☐ No Complaints of this type
- ☐ Difficulty with Memory
- ☐ Headaches
- ☐ Difficulty with Speech
- ☐ Dizziness
- ☐ Difficulty Walking
- ☐ Fainting
- ☐ Paralysis
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors

Cardiac

- ☐ No Complaints of this type
- ☐ Chest Pains
- ☐ Heart Racing
- ☐ Shortness of Breath while lying down
- ☐ Shortness of Breath with exertion
- ☐ Swelling in legs

Breathing

- ☐ No Complaints of this type
- ☐ Cough
- ☐ Shortness of Breath in general
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Painful Breathing

Hematologic

- ☐ No Complaints of this type
- ☐ Bruise Easily
- ☐ Nosebleeds
- ☐ Bleed Easily
- ☐ Blood Clots
- ☐ Enlarged Lymph Nodes
- ☐ Bleeding Gums

Gastrointestinal

- ☐ No Complaints of this type
- ☐ Painful Swallowing
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Gas/Bloating
- ☐ Change in Bowel Habit
- ☐ Difficulty Swallowing
- ☐ Yellow eyes or skin

Genitourinary

Men

- ☐ No Complaints of this type
- ☐ Painful Urination
- ☐ Bloody Urine
- ☐ Penile Discharge
- ☐ Frequent Urination
- ☐ Hesitancy in Urination
- ☐ Frequent Night Urination
- ☐ Urine Leakage
- ☐ Erectile Dysfunction

Women

- ☐ No Complaints of this type
- ☐ Vaginal Discharge
- ☐ Urine leakage
- ☐ Painful Urination
- ☐ Bloody Urine
- ☐ Frequent Urination
- ☐ Abnormal Vaginal Bleeding
- ☐ Pelvic Pain

Psychological

- ☐ No complaints of this type
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Phobias

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Health History Questionnaire

(Continued)

Name: ____ Date:____________________________________

Please check off all that apply for each body system

Vascular	Muscular/Skeletal	Endocrine
☐ No Complaints of this type	☐ No Complaints of this type	☐ No Complaints of this type
☐ Blue Fingers/Toes	☐ Joint Pain	☐ Intolerance to Cold
☐ Swelling in Extremities	☐ Joint Swelling	☐ Intolerance to Heat
☐ Varicose Veins	☐ Back Pain	☐ Excessive Thirst
☐ Pain in Legs with Walking	☐ Muscle Weakness	☐ Excessive Hunger
☐ Resting leg Pain	☐ Muscle Shrinkage	☐ Excessive Urination
	☐ Muscle Cramps	

Women only

Age at onset of menstruation: ___________________________ Date of last menstruation:___________________________

Number of pregnancies:__________ Number of live births:____________ Age at first live birth:__________

Are you currently breastfeeding? ○ Yes ○ No

Have you ever taken birth control pills or hormone therapy? ○ Yes ○ No

If yes, for how long? ____________________

Please list any physicians to whom you would like a report of your treatment sent: (write name of physician)

OB/Gyn:

Gastroenterologist:

Cardiologist:

Dermatologist:

Other:

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Glenn L. Sandler, MD and Craig P. Colliver are owners of Montgomery Surgery Center, L.P.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Montgomery Surgery Center, L.P.

3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Montgomery Surgery Center, L.P.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Montgomery Surgery Center, L.P. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Montgomery Surgery Center, L.P.

______________________________ Signature of Patient

______________________________ Signature of Parent or Guardian (if applicable)

______________________________ Type or Print Name of Patient

______________________________ Type or Print Name of Parent or Guardian (if applicable)

Dated:_________________________