

Walter R. Peters, M.D.  
Paul W. Humphrey, M.D.  
James B. Pitt, D.O.  
John G. Adams, M.D.  
Richard D. Coats, M.D.



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Scott A. Gard, M.D.  
Abigail Schulte, FNP-BC

3220 Bluff Creek Drive • Columbia, Missouri 65201 • (573) 443-8773

**Patient Information**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** Male Female

**Social Security #** \_\_\_\_\_ **Marital Status:** Single Married Divorced Widowed

**Ethnicity:** Non-Hispanic Hispanic

**Race:** White African American Asian Pacific Islander American Indian Unknown Refuse to Say

**Preferred Language:** English Spanish Other: \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Communication Preference:** Home Phone Cell Phone Mail Email

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **EXT:** \_\_\_\_\_

**Which Doctor Are You Seeing Today?** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact or Next of Kin:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Information**

**Primary Insurance Company:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**I.D. #** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **SS #:** \_\_\_\_\_

**Effective Date of Coverage:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**I.D. #** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **SS #:** \_\_\_\_\_

**Effective Date of Coverage:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Authorization**

\_\_\_\_\_  
Patient Signature Date (Power of Attorney or Authorized Signature if Minor)

**I understand that I am responsible for my payment of services to Columbia Surgical Associates, Inc. I authorize the Release of any and all medical records information necessary to process claim/s and request payment from my Insurance Company as complies with HIPAA regulations.**

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**WORKER'S COMPENSATION/LIABILITY INFORMATION**

Is this visit related to a work injury? \_\_\_\_ Yes \_\_\_\_ No    Is this visit related to an auto accident? \_\_\_\_ Yes \_\_\_\_ No

Is this visit related to any other liability claim? \_\_\_\_ Yes \_\_\_\_ No

I have written authorization from the Insurance Company for these services: \_\_\_\_ Yes \_\_\_\_ No

This claim has been filed with the Missouri State Dept. of Worker's Compensation: \_\_\_\_ Yes \_\_\_\_ No

If "yes" please give the report of injury number (#) \_\_\_\_\_.

**I AUTHORIZE COLUMBIA SURGICAL ASSOCIATES, INC. AND/OR IT'S REPRESENTATIVE TO RELEASE MY MEDICAL RECORDS OR DISCUSS CONTINUED TREATMENT OF CARE WITH MY WORKMAN'S COMPENSATION CARRIER OR ITS REPRESENTATIVE.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Do you now or have you recently had any problems related to the following systems? Check YES or NO. If you mark yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.**

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Cardiovascular:**

Chest pain Y  N   
Palpitations/Murmur Y  N   
Leg swelling Y  N   
Irregular Heartbeat Y  N

Other: \_\_\_\_\_

**Constitutional Symptoms:**

Fever Y  N   
Chills Y  N   
Headache Y  N   
Weight Loss Y  N   
Weight Gain Y  N

Other: \_\_\_\_\_

**Endocrine:**

Excessive Thirst Y  N   
Too hot/cold Y  N   
Tired/Sluggish Y  N

Other: \_\_\_\_\_

**Eyes:**

Blurred Vision Y  N   
Double Vision Y  N   
Pain Y  N

Other: \_\_\_\_\_

**Integumentary/ Breast:**

Skin rash Y  N

**Breast**

Nipple Discharge Y  N   
Breast Pain Y  N   
Mammogram Y  N

Date \_\_\_\_\_  Normal  Abnormal

**Genitourinary:**

Urine retention Y  N   
Painful urination Y  N   
Urinary frequency Y  N   
Difficulty Urinating Y  N   
PSA (prostate blood test) Y  N

Date \_\_\_\_\_  Normal  Abnormal

Other: \_\_\_\_\_

**Hematological/Lymphatic:**

Swollen glands Y  N   
Blood clotting problem Y  N

Other: \_\_\_\_\_

**Musculoskeletal:**

Joint Pain Y  N   
Neck Pain Y  N   
Back Pain Y  N   
Assistive devices Y  N

Other: \_\_\_\_\_

**Neurological:**

Seizures Y  N   
Tremors Y  N   
Dizzy Spells Y  N   
Numbness/Tingling Y  N

Other: \_\_\_\_\_

**Psychological:**

Do you suffer from depression? Y  N   
Do you feel severely anxious or nervous? Y  N

Other: \_\_\_\_\_

**Respiratory:**

Wheezing Y  N   
Frequent cough Y  N   
Chronic Cough Y  N   
Shortness of breath Y  N

Other: \_\_\_\_\_

**Gastrointestinal:**

Abdominal pain Y  N   
Nausea/Vomiting Y  N   
Indigestion/Heartburn Y  N   
Ulcer Y  N   
Intolerance to Greasy Food Y  N   
Blood in Stool Y  N   
Colon/Rectal Polyps Y  N   
Pain with Bowel Movement Y  N   
Jaundice Y  N   
Difficulty swallowing Y  N   
Have you had a colonoscopy? Y  N

When? \_\_\_\_\_

Results  Normal  Abnormal

Other: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**HISTORY OF PRESENTING ILLNESS:**

**REASON FOR OFFICE VISIT:** \_\_\_\_\_

What makes this better or worse? \_\_\_\_\_

Date illness started: \_\_\_\_\_ Severity of pain 1-10 (10 being worst) \_\_\_\_\_

Quality of pain (stabbing, pressure-like): \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HEALTH HISTORY:**

**Please list all surgeries:**

SURGERY		DATE	COMPLICATIONS
<input type="checkbox"/>	Hernia		
<input type="checkbox"/>	Gall Bladder		
<input type="checkbox"/>	Appendectomy		
<input type="checkbox"/>	Hysterectomy		
<input type="checkbox"/>	Orthopedic Surgery		
<input type="checkbox"/>	Other		
<input type="checkbox"/>	Other		
<input type="checkbox"/>	Other		
<input type="checkbox"/>	Other		

**Please list all Hospitalizations:**

HOSPITALIZATIONS	DATE	REASON

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**Patient Name:** \_\_\_\_\_

**Please Circle “Y” or “N” for any medical conditions YOU suffer from:**

Anemia	<b>Y</b>	<b>N</b>	Frequent Headache/Migraine	<b>Y</b>	<b>N</b>	Liver Disease/Jaundice	<b>Y</b>	<b>N</b>
Arthritis	<b>Y</b>	<b>N</b>	Gallbladder	<b>Y</b>	<b>N</b>	Meningitis	<b>Y</b>	<b>N</b>
Asthma	<b>Y</b>	<b>N</b>	Head Injury	<b>Y</b>	<b>N</b>	Multiple Sclerosis	<b>Y</b>	<b>N</b>
Bladder/Prostate Incontinence	<b>Y</b>	<b>N</b>	Hearing Loss	<b>Y</b>	<b>N</b>	Pneumonia	<b>Y</b>	<b>N</b>
Blood Clots	<b>Y</b>	<b>N</b>	Heart Attack/Surgery or Stents	<b>Y</b>	<b>N</b>	PVD (peripheral vascular disease)	<b>Y</b>	<b>N</b>
Blood Transfusion	<b>Y</b>	<b>N</b>	Heart Catheterizations	<b>Y</b>	<b>N</b>	Rheumatic Fever	<b>Y</b>	<b>N</b>
Cancer - Breast	<b>Y</b>	<b>N</b>	Heart Disease	<b>Y</b>	<b>N</b>	Stroke	<b>Y</b>	<b>N</b>
Cancer - Colon	<b>Y</b>	<b>N</b>	Hepatitis	<b>Y</b>	<b>N</b>	Thyroid Disorder	<b>Y</b>	<b>N</b>
Cancer- Other: _____	<b>Y</b>	<b>N</b>	Hiatal Hernia/Reflux	<b>Y</b>	<b>N</b>	Tuberculosis	<b>Y</b>	<b>N</b>
Colon/Rectal Polyps	<b>Y</b>	<b>N</b>	High Blood Pressure	<b>Y</b>	<b>N</b>	Ulcers	<b>Y</b>	<b>N</b>
Diabetes	<b>Y</b>	<b>N</b>	High Cholesterol	<b>Y</b>	<b>N</b>	Varicose Veins	<b>Y</b>	<b>N</b>
Emphysema	<b>Y</b>	<b>N</b>	Kidney Disorder	<b>Y</b>	<b>N</b>	Weakness or Paralysis	<b>Y</b>	<b>N</b>
Epilepsy/Seizures	<b>Y</b>	<b>N</b>						

Please list any major or chronic illnesses not listed above:

NONE

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Patient Name: \_\_\_\_\_

## Family History

**Please Circle “Y” or “N” for any conditions YOUR FAMILY suffers from:**

FAMILY MEMBER			FAMILY MEMBER		
Anemia	Y	N	Hepatitis	Y	N
Asthma	Y	N	High Blood Pressure	Y	N
Abdominal Aneurysm	Y	N	High Cholesterol	Y	N
Blood Clots	Y	N	Kidney Disorder	Y	N
Blood Transfusion	Y	N	Liver Disease/Jaundice	Y	N
Cancer - Breast	Y	N	Multiple Sclerosis	Y	N
Cancer - Colon	Y	N	Problems with anesthesia	Y	N
Cancer- Other: _____	Y	N	PVD (peripheral vascular dis)	Y	N
Colon/Rectal Polyps	Y	N	Rheumatic Fever	Y	N
Diabetes	Y	N	Stroke	Y	N
Emphysema	Y	N	Thyroid Disorder	Y	N
Gallbladder	Y	N	Tuberculosis	Y	N
Heart Attack /Surgery or Stents	Y	N		Y	N

### SOCIAL HISTORY:

Who lives in your home? \_\_\_\_\_

Your Occupation: \_\_\_\_\_  Full-Time  Part-Time  Student  Retired

• Are you currently working?  YES  NO-Last day: \_\_\_\_\_  Unemployed  Disabled

○ Reason not working: \_\_\_\_\_

• Do you smoke?  YES  NO *How Much?* \_\_\_\_\_ per Day *For How Long?* \_\_\_\_\_

• Have you quit?  YES  NO *When?* \_\_\_\_\_

• Do you drink over six cups of caffeinated beverages per day?  YES  NO

• Do you Drink Alcohol?  YES  NO

• *How much?*  Weekly  Daily  Monthly  Rarely

#### FOR WOMEN ONLY:

At what age did you start having periods? \_\_\_\_\_

Are you still having regular menstrual periods? \_\_\_\_\_

Are you or have you ever been on hormone replacement therapy?  YES  NO

How many times have you been pregnant? \_\_\_\_\_

Do you think you may currently be pregnant?  YES  NO

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**Patient Name:** \_\_\_\_\_

Have you had any miscarriages?  NO  YES If so, how many? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Your age at the time of your first pregnancy: \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_  Normal  Abnormal

Where was your last mammogram? \_\_\_\_\_

**FOR MEN ONLY:**

Have you had a prostate exam?  NO  YES  
If so, When? \_\_\_\_\_

Have you had a PSA (Prostate specific antigen) test?  NO  YES  
If yes, when \_\_\_\_\_ PSA Level \_\_\_\_\_

*The above information is completed to the best of my knowledge*

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Name:**

## CURRENT MEDICATION LIST

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>ALLERGIES</b>	<b>REACTION</b>

<b>PHARMACY</b>	<b>CROSS ROADS</b>		<b>PHONE NUMBER</b>
<b>PRESCRIPTION/OVER THE COUNTER MEDICATION NAME</b>	<b>DOSAGE</b>	<b>FREQUENCY</b>	<b>ROUTE/TOPICAL SITE</b>
<b>HERBAL MEDICATION NAME</b>	<b>DOSAGE</b>	<b>FREQUENCY</b>	<b>ROUTE/TOPICAL SITE</b>