Friedman Surgical Group, P.C.

WELCOME TO OUR OFFICE

Date _____ Birth date _____

Last name _____ First name _____

Address _____ City_____ ZIP_____

Phone #_____Alternate #_____

Sex: (M) (F) SS#_____ Marital: (S) (M) (W)

Employer/ Occupation _____

Spouse name _____

Primary Doctor_____ Referring _____

Cardiologist: _____ Oncologist _____

Your Pharmacy _____ City _____

Cross-streets _____

HEALTH INSURANCE (if patient is not subscriber)

1st insurance : SUBSCRIBER'S NAME_____ birthdate_____

2nd insurance: SUBSCRIBER'S NAME _____ birthdate_____

Please list your allergies

_____

Please list your medications

_____

_____

_____

_____

Please turn the page over

7/2025

MEDICAL HISTORY

Have you ever been treated or are being treated for any of the following?
Please check ALL that apply

	AIDS/ Other STD
	Anemia
	Anesthesia Problems
	Arthritis/ Rheumatism
	Asthma
	Back Trouble
	Bariatric Surgery
	Bleeding Tendencies
	Chronic Bronchitis
	Cancer
	Colitis/ Bowel Problem
	Depression
	Diabetes
	Emphysema/ Phlebitis
	Epilepsy
	Gallbladder Disease

	Gout
	Heart issues
	Hemorrhoids
	Hepatitis/ Jaundice
	Hernia
	High Blood Pressure
	Kidney/ Bladder
	Migraine Headaches
	Pregnancy
	Prostate issues
	Sickle Cell Disease
	Stomach Ulcer
	Stroke
	Thyroid Problems
	Other Chronic Issues

Do you smoke cigarettes, cigars, marijuana, chew tobacco, former smoker, never

Alcohol intake 1-2 /day 1-2/ weekend more social rare never

Surgical History

Please, list surgeries you have had in the past

Surgery When Where

_____

_____

_____

_____

_____

_____

I confirm that the information provided is accurate and complete to the best of my knowledge

Signature Date

_____ _____

Patient / responsible party