Abington Surgical Associates
Orlando C. Kirton, MD, FACS, MCCM, FCCP
Kristin M. Noonan, MD, FACS, FASMBS

Dear Patient:

We are happy that you have chosen Abington Surgical Associates and we look forward to meeting you.

What to bring to your first appointment:

- Picture ID – We are required by law to verify your identify. The intent of this law is to protect you from identity theft.
- Your insurance card/cards
- A list of your current medications, including all vitamins and nutritional supplements
- Both films an reports for any recent radiology testing you have had related to the condition for which you are being treated if it was done somewhere other than Abington Memorial Hospital
- Completed patient information packet, which is included with this instruction letter.

If any of the information above is missing, your appointment and your treatment may be delayed, and your appointment may need to be rescheduled.

If your insurance plan requires a referral, we ask that you call your doctor's office and ask them to provide a referral. **PLEASE MAKE SURE THE REFERRAL IS WRITTEN OUT FOR ABINGTON SURGICAL ASSOCIATES.**

If your insurance plan requires a co-payment, it is expected at the time of your scheduled office visit. Our office accepts the following: Cash, Checks, Credit Cards

Please call our office with any questions as we will be happy to answer them.

Sincerely,

Abington Surgical Associates

Price Medical Office Building – Suite 302 ■ 1245 Highland Avenue ■ Abington, PA 19001-3788

■ Telephone 215-481-7462 – ■ Fax 215-481-3975

Abington Jefferson Health

ABINGTON SURGICAL ASSOCIATES

Patient Name _____ Today's Date _____

Date of Birth _____ Home Phone_____-_____

Cell/Work Number _____Emergency Contact _____

Relationship _____Phone Number_____

Referring Provider _____ Phone Number _____

Primary Care Provider _____ Phone Number _____

Reason for today's visit _____

Age: _____ SS# _____ Height _____ Weight _____

To your knowledge, do you have or have you had any of the following

Respiratory (lung) issues	**Yes**	**No**	**Hematology (Blood/Clotting) Issues**	**Yes**	**No**
Recent cold, bronchitis, or pneumonia			Anemia (low blood count)		
Asthma or wheezing			Sickle cell or trait		
Tuberculosis (TB)			Easy bruising or bleeding		
Sleep apnea or snoring			Blood transfusion		
Shortness of breath w/minimal exercise			Phlebitis/DVT/PE/blood clots		
Chronic cough			Hemophilia or Von Willebrand disease		
Other lung or blood issues (please explain)					
Cardiac (heart/circulation) issues			**Gastrointestinal (digestion) issues**		
Irregular heart beat/palpitations			Liver disease/hepatitis/jaundice		
Mitral valve prolapse			Gallbladder/stones, or inflammation		
Heart murmur			Pancreatitis		
Rheumatic fever			Chronic heartburn/reflux		
High blood pressure			Barrett's esophagus		
High cholesterol			Esophageal or stomach cancer		
Heart attack			GI bleed or ulcer		
Heart failure			Hiatal hernia		
Chest tightness/angina			Crohn's or irritable bowel disease (IBS)		
Poor circulation in your legs or feet			Diverticulitis, diverticulosis		
Sores or ulcers that don't heal			Rectal bleeding		

Name: _____ DOB: _____

Other heart or digestion issues (please explain):

Neurologic Issues	**Yes**	**No**	**Endocrine (Hormone) Issues**	**Yes**	**No**
Stroke/TIA/mini stroke			Thyroid disorders		
Multiple Sclerosis or Polio			Diabetes		
Weakness or paralysis (temp or perm)			Polycystic ovary syndrome (PCOS)		
Head injury			Adrenal disorder		
Epilepsy or seizures			Cushing's or Addison's disease		
Chronic cough					
Other neurologic or hormone issues (please explain):					
Urologic Issues			**Miscellaneous Issues**		
Prostate enlargement or cancer			Chronic pain, location		
Kidney or bladder cancer			Loose, chipped or removable teeth		
Kidney stones			Temporal mandibular joint, dis. (TMJ)		
Bladder retention			Scoliosis (curvature of the spine)		
Incontinence (bladder)			Anesthesia complications		
Frequency or urgency of urination			Glasses, contact lenses		
Pain or burning with urination			Assistive devices (walker, cane, etc)		
Immunicological (Immune System) Issues					
Other issues (please explain):					

Please list below all previous surgical procedure and hospitalizations

Procedure/Hospitalization	**Dates**	**Location**

Please list all family medical history; please include diabetes, heart disease and cancer

Family Member	**Alive**	**Deceased**	**Medical History**
Mother			
Father			
Sibling			
Sibling			

Please list your social history

Substance	**Never**	**Current**	**Last Used**	
Tobacco				**Packs per day:**
Marijuana				
Alcohol				**Drinks per week:**
Recreational drugs				
Other				

Name: _____ DOB: _____

Please list all medications including over the counter medications, vitamins and supplements

Name	Dose	Frequency

Please list all allergies and the reaction

Allergen/Drug	Reactions

Are you allergic to Latex? Yes _____ No _____
If so, what is your reaction? _____

Are you allergic to Contrast Dye? Yes _____ No _____
If so, what is your reaction? _____

Are you allergic to Betadine or Iodine? Yes _____ No _____
If so, what is your reaction? _____