CONFIDENTIAL PATIENT INFORMATION

Date ____________

Name: ______________________ Home Phone: ______________

Address: ______________________ Social Security No.: ______________

City: ______________ State: __ Zip ______ Drivers License No.: ______________

Age: ____ Birth date: __/__/__ How many children: ____ Marital Status: S M Other Sex M F

Occupation: ______________________ Employer: ______________

Address: ______________________ Office Phone: ______________

Name of Spouse: ______________________ Occupation: ______________

Employer: ______________________ Office Phone: ______________

Patients Nearest Relative: ______________________ Phone: ______________

Referred By: ______________________ Date of Last Physical Exam: ______________

Have you ever suffered from

1. Dizziness	☐ Yes/☐ No		8. Asthma	☐ Yes/☐ No
2. Backaches	☐ Yes/☐ No		9. Neuritis	☐ Yes/☐ No
3. Heart Trouble	☐ Yes/☐ No		10. Digestive Disorders	☐ Yes/☐ No
4. Diabetes	☐ Yes/☐ No		11. Nervousness	☐ Yes/☐ No
5. Tuberculosis	☐ Yes/☐ No		12. Sinus Trouble	☐ Yes/☐ No
6. Arthritis	☐ Yes/☐ No		13. Anemia	☐ Yes/☐ No
7. Headaches	☐ Yes/☐ No		14. Cancer	☐ Yes/☐ No

Purpose of Appointment: ______________________

Other Doctors seen for this Condition: ______________________

Have you been treated for any health condition by a physician in the past year? ☐ Yes /☐ No

Describe: ______________________

Remarks and additional information: ______________________

____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: ______________________

Are you insured? ☐ Yes /☐ No Company: ______________ Phone: ______________

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits to be paid directly to the doctor and I am financially responsible for non covered services. I also authorize the doctor to release any information required to process this claim.

Patient's Signature ______________________ Date: ______________

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that ______________ will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to ______________ will be credited to my account on reciept. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature ______________________ Date: ______________

Guardian or Spouse's Signature ______________________ Date: ______________

Information Taken By ______________________ Date: ______________

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HEALTH HISTORY *Check all that apply*

Patient Initials: ______

Conditions You Have Had

- ❑ AIDS / HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ ALS (Lou Gerhig's)
- ❑ Alzheimer's
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Birth Defects
- ❑ Bleeding Disorder
- ❑ Breast Cancer
- ❑ Cancer
- ❑ Colitis / Crohn's / IBS
- ❑ Colon Cancer
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ Drug Abuse
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes / Shingles
- ❑ High Blood Pressure
- ❑ High cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Illness
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Parkinson's
- ❑ Pneumonia
- ❑ Prostate Cancer
- ❑ Sickle Cell Anemia
- ❑ Stroke
- ❑ Suicide
- ❑ Thyroid / Goiter
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other:

Devices Currently Used

- ❑ Pacemaker
- ❑ Implants of any kind
- ❑ Joint Replacement
- ❑ Braces (neck, back, knee, etc)
- ❑ Orthotics

Current / Past

General

- ❑ ❑ Pain Not Relieved by Rest
- ❑ ❑ Fever
- ❑ ❑ Chills
- ❑ ❑ Night Sweats
- ❑ ❑ Fatigue
- ❑ ❑ Weight Loss or Gain
- ❑ ❑ Headaches
- ❑ ❑ Tremors
- ❑ ❑ Dizziness
- ❑ ❑ Numbness / Tingling
- ❑ ❑ Loss of Sensation
- ❑ ❑ Change in Memory

Last Physical Exam:____/____

❑ Normal ❑ Abnormal

Skin

- ❑ ❑ Dryness
- ❑ ❑ Itching
- ❑ ❑ Bruise Easily
- ❑ ❑ Change in Mole(s)
- ❑ ❑ Nail Changes
- ❑ ❑ Hair Changes
- ❑ ❑ Acne

Eye, Ear, Nose, Throat

Last Eye Exam:____/____

- ❑ ❑ Eye Pain
- ❑ ❑ Glaucoma
- ❑ ❑ Change in Vision
- ❑ ❑ Ear Pain
- ❑ ❑ Ear Ringing
- ❑ ❑ Change in Hearing
- ❑ ❑ Change in Smelling
- ❑ ❑ Change in Taste
- ❑ ❑ Change in Voice
- ❑ ❑ Trouble Swallowing
- ❑ ❑ Hoarseness

Gastrointestinal

- ❑ ❑ Bowel Incontinence
- ❑ ❑ Change in Bowel Habits
- ❑ ❑ Abdominal Pain
- ❑ ❑ Nausea
- ❑ ❑ Bloating
- ❑ ❑ Belching / Gas
- ❑ ❑ Heartburn
- ❑ ❑ Indigestion
- ❑ ❑ Constipation
- ❑ ❑ Diarrhea

Current / Past

- ❑ ❑ Undigested Food
- ❑ ❑ Hemorrhoids
- ❑ ❑ Poor Appetite
- ❑ ❑ Change in Appetite
- ❑ ❑ Bloody Stool
- ❑ ❑ Black / Tarry Stool
- ❑ ❑ Diverticulitis
- ❑ ❑ Vomiting
- ❑ ❑ Vomiting Blood
- ❑ ❑ Ulcers

Last Colonoscopy:____/____

❑ Normal ❑ Abnormal

Respiratory

- ❑ ❑ Difficult Breathing
- ❑ ❑ Chronic Cough
- ❑ ❑ Phlegm
- ❑ ❑ Cough Up Blood
- ❑ ❑ Wheezing

Cardiovascular

- ❑ ❑ Pain Over Heart
- ❑ ❑ High Blood Pressure
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Irregular Heartbeat
- ❑ ❑ Murmur
- ❑ ❑ Palpitations
- ❑ ❑ Previous Heart Trouble
- ❑ ❑ Cold or Blue Hands / Feet
- ❑ ❑ Swelling of Ankles
- ❑ ❑ Varicose Veins

Last Cholesterol Test:____/____

❑ Normal ❑ Abnormal

Genitourinary

- ❑ ❑ Bladder Incontinence
- ❑ ❑ Frequent Urination
- ❑ ❑ Overnight more than Twice
- ❑ ❑ Painful Urination
- ❑ ❑ Difficulty Starting Flow
- ❑ ❑ Blood in Urine
- ❑ ❑ Urinary Infection
- ❑ ❑ Kidney Stones
- ❑ ❑ Discharge
- ❑ ❑ STD

Current / Past

Men Only

- ❑ ❑ Testicular Swelling / Pain
- ❑ ❑ Prostate Problems

Last Prostate Exam:____/____

❑ Normal ❑ Abnormal

Women only

- ❑ ❑ Infertility
- ❑ ❑ Hot flashes
- ❑ ❑ Lumps in breast
- ❑ ❑ Vaginal discharge

Last PAP: ____/____

❑ Normal ❑ Abnormal

Last Mammogram:____/____

❑ Normal ❑ Abnormal

Menstrual Periods

Age Onset: ______

Avg. Days of Flow: ____

Avg. Cycle: _____ days

Menstrual Flow

❑ *Reg.* ❑ *Irreg.*

❑ *Pain / cramps*

Menopause - age: _____

Are you pregnant?

❑ No ❑ Yes: ____ mos

Birth control method:

____

Number of Children

_____ Born Alive

_____ Cesarean

_____ Premature

_____ Stillborn

_____ Miscarriages

Childhood Diseases

- ❑ Chicken Pox
- ❑ Measles / Mumps
- ❑ Polio
- ❑ Rheumatic Fever

Immunizations (Dates)

Polio: ____/____

Tetanus: ____/____

Hepatitis: ____/____

Flu: ____/____

Pneumonia: ____/____

Lifestyle

Water: cups/day ___

Exercise: x/week ___

Sleep: hours/night ___

Alcohol: drinks/day ___

Smoke: packs/day ___

❑ Previous Smoker

Start Date: ____/____

End Date: ____/____

Please describe your average daily diet. *Be specific.*

Morning: ____________________

Lunch: ____________________

Dinner: ____________________

Snack: ____________________ How Often?: ____________