

PATIENT INFORMATION

Please Print: All information is confidential

Today's Date _____ Patient Name _____

SS# _____ Male ___ Female ___ Birth Date _____ Home Phone () _____

Address _____ City _____ State _____ Zip _____

Patient's or Parents Employer _____ Work Phone () _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parents Name _____ Employer _____ Work Phone () _____

Person to contact in case of Emergency _____ Phone () _____

Responsible Party

Name of Person Responsible For Bill _____ Relationship to Patient _____

Address _____ Home Phone () _____

Employer _____ Work Phone () _____

Birth Date _____ Is This Person Currently A Patient At Our Office Yes ___ No ___

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security Number _____

Name of Employer _____ Work Phone () _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ ID# _____ Group# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Do you have a deductible? Yes ___ No ___ If yes how much? _____

Do You Have Additional Insurance? Yes No If yes, please complete the following.

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security Number _____

Name of Employer _____ Work Phone () _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ ID# _____ Group# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Do you have a deductible? Yes ___ No ___ If yes how much? _____

Any portion not paid for by your insurance is your responsibility and is due upon receipt of our statement. Any attorney or collection fees incurred due to delinquency in payment will be charged to the patient. There is a \$30.00 fee for all returned checks.

X _____
Signature of Patient or Parent of Minor Date

I authorize release of any information concerning my (or my child's) care advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
Signature of Patient or Parent of Minor Date

Name _____ Appointment Date _____

The following questionnaire is used to obtain a survey of your past and present medical history. Please check the statements that apply to you and circle any that you do not understand or may have a question about. Thank you.

I. GENERAL

- 1. Recent loss in weight
- 2. Swelling of any part of your body
- 3. Any growth, tumor, unusual mole or wart
- 4. Unexplained fever
- 5. Ulcers, skin rash, or cuts that will not heal
- 6. Chronically tired and fatigued
- 7. Difficulty in sleeping
- 8. Recent change in appetite
- 9. Drink water excessively
- 10. A recent injury
- 11. Been denied or up-rated on life insurance
- 12. Been rejected or discharged from the military for medical reasons

II. SPECIAL SENSES

- 1. Any blurred or double vision
- 2. Vision getting worse
- 3. Wear glasses
- 4. Any ringing in your ears
- 5. Hearing impaired
- 6. A change in your taste or smell
- 7. Your nose chronically "stopped up"
- 8. Frequent sore throats or colds
- 9. Any hoarseness of your voice

III. SPECIAL SENSES

- 1. Unexplained stomach trouble
- 2. Indigestion
- 3. Nausea and/or vomiting
- 4. Vomiting blood
- 5. Jaundice
- 6. Intolerance to fatty acids
- 7. Allergy to any food
- 8. Unexplained abdominal pain or distress
- 9. Change in bowel movement habits
- 10. Change in color of bowel movements
- 11. Presence of blood in your stool
- 12. Painful bowel movements
- 13. Presence of hemorrhoids or rectal itching
- 14. Diarrhea or constipation
- 15. Ever had a pilonidal cyst

IV. GENITO-URINARY

- 1. Bloody urine
 - 2. Is your urine cloudy
 - 3. Do you have to urinate frequently
 - 4. Do you have the desire to urinate frequently
 - 5. Do you have painful urination
 - 6. Urinate frequently at night
 - 7. Back Pain
- MALES ONLY**
- 8. Do you have ulcer or sores on your penis
 - 9. Any swelling of the testicle
 - 10. Do you have a problem obtaining or maintaining an erection

V. CARDIOVASCULAR & RESPIRATORY

- 1. Rapid beating of your heart
- 2. Swelling of ankles or feet
- 3. Shortness of breath
- 4. Swelling of your abdomen
- 5. Pain in your chest
- 6. Pain and/or numbness of your arms
- 7. Pain in your legs while walking
- 8. Coldness or skin color changes of feet or hands
- 9. Sensitive to cold temperatures
- 10. Tightness in your chest
- 11. Do you have asthma
- 12. Chronic cough
- 13. Have you coughed up blood or sputum
- 14. Had high or low blood pressure
- 15. Wheezing type of breathing
- 16. Have you had Rheumatic Fever
- 17. Bled excessively after an injury or tooth extraction

VI. MUSCULOSKELETAL

- 1. Have you had a dislocation or a fracture
- 2. Pain or stiffness in any joints of your body
- 3. Any back pain
- 4. Decrease in the size of any muscles
- 5. Weakness of any part of your body
- 6. Wear a brace of any type
- 7. Bursitis
- 8. Arthritis
- 9. Had a "Trick Joint" (knee, shoulder, etc.)

COMPREHENSIVE CARE DATA BASE ADULT

Name _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

Phone _____ Occupation/ Employer _____

1. Please list any medication to which you are allergic or which you are unable to take for any reason. _____
2. Please list any medication, either prescription or over the counter (birth control pills, aspirin, etc.) that you are taking on a regular basis. _____
3. Please list all of your surgeries (tonsillectomy, appendectomy, etc.)

Year	Surgery	Reason	Surgeon

4. Please list any serious illnesses that you have had in the past or have now (diabetes, blood pressure trouble, etc.).

Year of Onset	Illness	Condition at Present

Preventive Health Care Information

1. Date of most recent chest x-ray _____ EKG _____ PAP Test
Were they all normal? Yes No Explain _____
2. Date of most recent tetanus immunization _____
3. Have you ever had mumps? Yes No or date of mumps vaccine _____
4. Have you ever had rubella (3-day measles)? Yes No or date of rubella vaccine
Ht. _____ Wt. _____

Personal History

1. Marital Status: Single _____ Yr. Married _____ Yr. Separated _____ Yr. Divorced _____
Yr. Widowed _____
Have you been married more than once? Yes No
Age of children from this marriage (if any) _____
Age of children from previous marriage (if any) _____
2. Education (highest grade or degree achieved) _____

FAMILY HISTORY

Mark those diseases you have had. If you know other members of the family with these diseases, please mark this also. (X) = Patient (M) = Mother (F) = Father (R) = Blood Relative (BIS) = Brother or Sister (SP) = Spouse.

x	M	F	R	B/S	SP	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Joint Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer

RISK ASSESSMENT

1. Exposure

Mark those to which you have frequently been exposed.

- Chemicals, cleaning fluids, oils
- Loud noise
- Asbestos or cement dust
- X-rays or radio active materials

2. Alcohol

- Never drink alcohol
- 3-4 times yearly
- Once a week
- 2-3 times per week
- Drink daily
- Drink excessively
- Beer 0 wine 71 liquor
- Have quit drinking alcohol.

Specify time length _____

3. Tobacco

- Never use tobacco cigarettes
- Less than 1 pack per day
- 1-2 packs per day
- 2-3 packs per day
- Over 3 packs per day _____

How many years?

Other

- smoke cigars
- smoke pipe
- I quit using tobacco.

Specify time length _____

4. Cups of Coffee per day

Comments:

Family	Year of Birth Health Status			Deaths		Age
	Year of Birth	Good	Poor	Cause of Death		
Father:				If a relative you have listed has died, Write the cause of death and the age At death in the columns below		
Mother:						
Brothers or Sisters:						
Spouse:						
Children:						